

THE PROFESSIONAL IDENTITY OF OCCUPATIONAL THERAPISTS

AN EMPIRICAL STUDY

ROSEMARIE W MASON

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ABSTRACT

There has been an understanding that occupational therapists suffer from a weak professional identity. This qualitative study examined the ways in which the professional identity of occupational therapists was perceived from the stance of practitioners, educators, and those working for the College of Occupational Therapists (COT) and the Council for Professions Supplementary to Medicine (CPSM).

There are many ways of defining 'profession'. In this case the perspective of symbolic interaction was taken and Becker's (1977), explanation of it as a symbolised concept was used. This framework was used to generate an interview schedule for 50 in-depth interviews, which facilitated an exploration of the actions that were undertaken to expand professional status, how individuals and collectives had interpreted those actions and the ways in which meaning was attributed to professionalism.

The research findings showed notable differences in interpretation between practitioners and organising bodies. Practitioners were confident that occupational therapy could claim a discrete body of knowledge but collective actions to align the skill to science had undermined its value. Changes in education, whilst beneficial to status, have weakened the capacity of the profession to control how it is managed. Government measures to monitor the competence of all health professionals have placed a greater imperative on occupational therapists' self-regulatory mechanisms to be visibly effective. A code of ethics is important for professional cohesion and has more potency than previously thought but events have made it difficult for occupational therapists to live a service ideal.

In essence the profession was not acting as a cohesive unit. There needs to be a stronger identification with a unique skill with more professional control over what form the work should take. There should be effective gate-keeping guarding against inappropriate admissions to the profession, effective monitoring of competence and discipline and a strong code of ethics. Socialisation has the potential to enhance individual professionalism and strengthen collective professional identity. Exploring these issues requires co-ordination, a purpose for which professional bodies, in this case COT, were established.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	5
LIST OF TABLES	6
LIST OF APPENDICES	7
ABBREVIATIONS	8
CHAPTER 1: INTRODUCTION	9
STRUCTURE OF THESIS	11
CHAPTER 2: LITERATURE REVIEW	13
HISTORICAL PERSPECTIVE OF PROFESSIONS	13
Professional Associations	15
The Rise and Fall of Professions	16
State Sanction	17
THEORIES OF PROFESSIONALISM	17
Functionalist Theories	17
Trait Theories	19
Interactionist Approach	22
Power Theories	24
The Professional Project	28
THE CONTEXT OF THE STUDY	31
The Symbol of Profession	31
The History of Occupational Therapy	33
CHAPTER 3: METHODOLOGY & METHODS	40
METHODS	45
INTERVIEW SCHEDULE	45
PILOT STUDY	47
SAMPLE	49
ETHICS	53
ROUTES OF ACCESS	54
INFORMED CONSENT	54
QUALITY OF DATA	54
ANALYTICAL STRATEGY	55
CHAPTER 4: FINDINGS: MONOPOLY OF KNOWLEDGE	59
THE UNIQUE SKILL OF OCCUPATIONAL THERAPY	60
THE VIEWPOINT OF PRACTITIONER OCCUPATIONAL THERAPISTS	62
Professional Skill	62
Skill Acquisition	65
Linking Professional Knowledge to Science	66

Theory	69
Mystification	72
Social Distance	74
Value to Society	79
Ownership of Professional Knowledge	80
THE VIEWPOINT OF COT	83
Professional Skill	83
Linking Professional Knowledge to Science	84
Role of COT	87
Ownership	88
THE VIEWPOINT OF EDUCATORS	89
Professional Skill	89
Linking Professional Knowledge to Science	90
THE VIEWPOINT OF CPSM	93
Professional Skill	93
Linking Professional Knowledge to Science	93
SUMMARY AND DISCUSSION	94
 CHAPTER 5: FINDINGS: CONTROL OF TRAINING INTO PROFESSIONAL PRACTICE	 100
OCCUPATIONAL THERAPY TRAINING	102
THE VIEWPOINT OF PRACTITIONERS	104
University Based Education	104
The Appropriateness of University Education	110
Knowledge and Theory Development	112
Weeding out Unsuitable Students	113
The Essential Things to Study	115
Tedious Aspects of Occupational Therapy	117
Enjoyable Aspects of Occupational Therapy	118
THE VIEWPOINT OF COT	120
University Based Education	120
Control of Occupational Therapy Course Content	121
Knowledge and Theory Development	123
THE VIEWPOINT OF EDUCATORS	125
University Based Education	125
Control of Occupational Therapy Course Content	126
Knowledge and Theory Development	129
THE VIEWPOINT OF CPSM	131
University Based Education	131
Control of Occupational Therapy Course Content	132
SUMMARY AND DISCUSSION	132
 CHAPTER 6: FINDINGS: ENTRANCE TO THE PROFESSION	 135
STATE REGISTRATION FOR OCCUPATIONAL THERAPISTS	136
THE VIEWPOINT OF PRACTITIONERS	138

State Registration	138
Character Screening	140
Protection of Title	142
THE VIEWPOINT OF COT	144
State Registration	144
Character Screening	146
Protection of Title	147
THE VIEWPOINT OF EDUCATORS	149
State Registration	149
Character Screening	149
Protection of Title	150
THE VIEWPOINT OF CPSM	151
State Registration	151
Character Screening	152
Protection of Title	153
SUMMARY AND DISCUSSION	153
CHAPTER 7: FINDINGS: CODE OF ETHICS	156
OCCUPATIONAL THERAPISTS' CODE OF ETHICS	158
THE VIEWPOINT OF PRACTITIONERS	160
Frequency of the Code of Ethics being read	160
The Place of Ethics in Day to Day Work	161
The Function of the Code of Ethics	162
The Role of COT	167
THE VIEWPOINT OF COT	171
The Function of the Code of Ethics	171
Membership of COT	172
THE VIEWPOINT OF EDUCATORS	175
The Function of the Code of Ethics	175
Membership of COT	176
THE VIEWPOINT OF CPSM	178
The Function of the Code of Ethics	178
Membership of COT	179
SUMMARY AND DISCUSSION	179
CHAPTER 8: FINDINGS: SERVICE IDEAL	183
THE SERVICE IDEAL FROM THE PERSPECTIVE OF OCCUPATIONAL THERAPY	185
THE VIEWPOINT OF PRACTITIONERS	186
Altruism	186
Rewards	188
Choice of Work Setting	189
Equity of Service Provision	194
Patient Choice	195
THE VIEWPOINT OF COT	200
Altruism	200
Rewards	200

Equity of Service Provision	201
THE VIEWPOINT OF EDUCATORS	204
Altruism	204
Rewards	204
Equity of Service Provision	206
THE VIEWPOINT OF CPSM	208
Altruism	208
Rewards	208
Equity of Service Provision	209
SUMMARY AND DISCUSSION	210
CHAPTER 9: FINDINGS: SOCIALISATION	213
THE VIEWPOINT OF PRACTITIONERS	216
Occupational Therapy in Lay Culture	216
Career Direction	219
Fieldwork Placements	221
Role Models	225
Role Transition	228
Lifetime Commitment	236
THE VIEWPOINT OF COT	240
Lifetime Commitment	240
THE VIEWPOINT OF EDUCATORS	242
Lifetime Commitment	243
THE VIEWPOINT OF CPSM	244
Lifetime Commitment	244
SUMMARY AND DISCUSSION	245
CHAPTER 10: CRITIQUE OF STUDY	248
CHAPTER 11: IMPLICATIONS	253
IMPLICATIONS FOR PRACTICE EPISTEMOLOGY	253
IMPLICATIONS FOR EDUCATION	255
IMPLICATIONS FOR COT	257
IMPLICATIONS FOR PROFESSIONAL IDENTITY	258
OUTLINE OF IDEAS FOR FUTURE STUDIES	261
CHAPTER 12: CONCLUSIONS	264
MONOPOLY OF KNOWLEDGE	265
CONTROL OF ENTRY INTO PROFESSIONAL PRACTICE	267
ENTRANCE TO THE PROFESSION	268
CODE OF ETHICS	269
SERVICE IDEAL	271
SOCIALISATION	272
REFERENCES	274
APPENDICES	287

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LIST OF TABLES

TABLE 1: Profile of Practitioner Occupational Therapists	51
TABLE 2: Number of times each category for monopoly of knowledge was mentioned	299
TABLE 3: Number of times each category for control of training into professional practice was mentioned	303
TABLE 4: Number of times each category for entrance to the profession was mentioned	306
TABLE 5: Number of times each category for code of ethics was mentioned	308
TABLE 6: Number of times each category for service ideal was mentioned	311
TABLE 7: Number of times each category for socialisation was mentioned	316
TABLE 8: The Attractive Fields of Occupational Therapy	190
TABLE 9: The Unattractive Fields of Occupational Therapy	192
TABLE 10: Turning Points towards Accepting Professional Identity	234

LIST OF APPENDICES

APPENDIX 1: Interview schedule for occupational therapy practitioners	287
APPENDIX 2: Interview schedule for COT members/educators/CPSM members	291
APPENDIX 3: Gatekeeper letter	293
APPENDIX 4: Guidelines used when giving information to potential participants	294
APPENDIX 5: Letter confirming consent	296
APPENDIX 6: Monopoly of knowledge codes and categories	297
APPENDIX 7: Control of training into professional practice codes and categories	301
APPENDIX 8: Entrance to the profession codes and categories	305
APPENDIX 9: Code of ethics codes and categories	307
APPENDIX 10: Service ideal codes and categories	309
APPENDIX 11: Socialisation codes and categories	314

ABBREVIATIONS

AOT	Association for Occupational Therapists
ADL	Activities of Daily Living
BAOT	British Association of Occupational Therapists
BJOT	British Journal of Occupational Therapists
BMA	British Medical Association
CHAI	Commission for Healthcare Audit and Inspection
CHI	Commission for Health Improvement
COT	College of Occupational Therapists
COTEC	Committee of Occupational Therapists for the European Communities
CPSM*	Council for Professions Supplementary to Medicine
DoH	Department of Health
HPC*	Health Professions Council
JVC	Joint Validation Committee
MMR	Mumps, Measles, Rubella
MOHO	Model of Human Occupation
NASUWT	National Association of School Masters and Women Teachers
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NSF	National Service Frameworks
OT	Occupational Therapist
OTN	Occupational Therapy News
QAA	Quality Assurance Agency
SAOT	Scottish Association of Occupational therapists
SARS	Severe Acute Respiratory Syndrome
UK	United Kingdom
USA	United States of America
WFOT	World federation of Occupational Therapists

As a general note I have chosen to use the noun ‘patient’ throughout most of the thesis except when citing another person. I did this because, when asked, the largest group of practitioners (44%) used the term, compared to 19% who used ‘client’ and 25% who used a mixture of both. Only 3% used ‘service user’.

* The Health Professions Council (HPC) came into operation in 2003 to replace the Council for the Professions Supplementary to Medicine (CPSM).

CHAPTER 1

INTRODUCTION

This chapter outlines the broad field of study and leads to the research question. It gives an indication of the potential benefits of the work and explains how the thesis has been structured.

Sociological definitions of the term 'profession' have undergone considerable historical change. Until the 1960s, most writers viewed professionals as being on a higher moral plane than business people. The trait theorists sought to isolate the essential elements of the classical professions of law, medicine and the ministry (Flexner 1915; Goode 1960). However, this attracted criticism for making the assumption that an 'ideal type' of profession existed, in addition to a lack of theoretical interconnection and inconsistency of the traits chosen. Subsequent to the 1960s, economists drew attention to the closed, monopolistic nature of the professional labour market, political scientists saw professions as privileged private governments, whilst policy makers saw them as narrow and insular in their vision of what was good for society (Freidson 1994). In 1972, Johnson concluded that professionalism (the process through which occupations could reach the end state of 'profession'), was a type of occupational control, especially for those areas of work where there was exposure to possible exploitation. Freidson (1994) introduced the 'folk concept' of a profession, in which people in society made their own judgements about who did and did not deserve the title. He argued that this was complicated by the fact that there must be 'a number of folk and thus a number of folk concepts'. Even so, he emphasised the necessity, despite the difficulties, of proceeding with some definition of profession since without it, professionalism is meaningless and there would be no clear end state to be studied. Hughes (1981) advised that, rather than struggling with competing definitions, it was more useful to look at the circumstances in which people in an occupation attempt to turn it into a profession and themselves into professional people. Becker (1977) observed that beneath the surface disagreements there were identifiable characteristics, which symbolised a morally praiseworthy kind of occupational organisation. He noted that new or aspirant professions try to adopt as many of the features of the symbol as possible.

Occupational therapy is one such example, emerging as it did in the 19th century having roots within nursing, social work and medicine. As a result professionalisation began within pre-existing organisational contexts (Hugman 1991). To date, it has published a code of ethics and established graduate level education, state registration and protection of title. There is an organising body, the College of Occupational Therapists and a regulatory body, the Health Professions Council. Yet, it has consistently been labeled as having a weak professional identity, something that was highlighted specifically in a report of a commission of inquiry produced by Blom-Cooper in 1989, and which continues

to be argued (Stewart 1992; Mocellin 1995; Creek & Ormston 1996; Mountain 1998).

The peak of the professionalism debate occurred between the 1920s and 1980s. The decline in recent interest has been attributed to a shift in emphasis from how professions were structured and what function they served to how such occupations have secured a privileged position in society (Macdonald 1995). Occupational therapy, being relatively new and small, has been largely ignored by the major writers on professionalisation: the functionalists, Tawney (1921), Parsons (1939), the trait theorists Goode (1960), Greenwood (1965), the power theorists, Johnson (1972), Freidson (1994) and symbolic interactionists, Becker (1977), Larson (1977), Hughes (1981). Nevertheless, much of their work is relevant to its activities. Etzioni's (1969) work on the semi-professions gave an understanding of the struggle for full professional status faced by occupations allied to health and welfare. Larkin (1983) was interested in the professional growth of occupations related to medicine but restricted his attention to opticians, chiropodists, radiographers and physiotherapists. Hugman (1991) included occupational therapy in his work on power relationships in the caring professions and more recently Richardson (1999) looked at professional development and socialisation for physiotherapists.

Within the occupational therapy literature, Mountain (1998) looked at the effects of professionalisation in the context of those working with the elderly mentally ill. Creek (1998) looked at the ways in which occupational therapists conceptualise beliefs about the nature and purpose of their professional practice. There is a lot of work covering the history of occupational therapy, including Paterson's (2002) study, which focussed on Scotland and Wilcock's (2002) extensive analysis. Whilst offering substantial and informative accounts they do not explain what motivated individuals and organisational collectives to transform occupational therapists into professional people, rather than let them remain as 'do-gooders' (Blom-Cooper 1989). Much of the work is from an American or Australian perspective (Quiroga 1995; Anderson & Bell 1998) and may be culturally specific. No one has analysed the process of professionalisation for occupational therapy in the United Kingdom from a sociological stance. There is little knowledge about what has influenced the actions of the organisational, statutory and educational bodies, how and what interactions have occurred and what have been the consequences. There has been no empirical work on perceived professional identity at this point in time. There is a tacit belief that occupational therapists are not confident in their professional status but the opinion of grass root practitioners is unknown. Before embarking on actions to improve professional status a benchmark needs to be found: how do occupational therapists perceive their status presently, what are their aspirations, how do they want to progress? These are the subjects of my thesis.

My interest in professionalisation developed whilst working as a practitioner occupational therapist. Most colleagues considered that they were respected for

performing well in a worthwhile job yet there seemed to be consistent efforts made by organisational bodies to enhance professionalisation. Introducing graduate level education was a case in point. Many practitioners were asking why such actions were necessary and that provided the motivation for me to find out. The intent of this research was to concentrate on the ways in which occupational therapists construct their world as professional people. I was concerned with their direct experiences and the ways in which they interpret the world of professionalism on a day to day basis. I wanted to consider viewpoints from all angles of the occupational therapy world. I was particularly interested in the interactions between organising and regulatory bodies and practitioners and the resulting consequences. The research question was refined to,

What are the ways in which occupational therapists consider themselves to be professional people?

The scope of the work covered an investigation of the following areas:

1. The concept of professionalism from the perspective of practitioner occupational therapists working in a health region in England.
2. The concept of professionalism from the perspective of those responsible for the organisation of occupational therapy.
3. The concept of professionalism from the perspective of those responsible for the education of occupational therapists.
4. The concept of professionalism from the perspective of those responsible for the regulation of occupational therapy.
5. To consider the implications for education and practice.

The resultant knowledge provides an overview of the ways in which the professional status of occupational therapy is perceived at this point in time from the perspectives of 'official' bodies and that of practitioners. It provides empirical evidence, which may be used to understand the implications of actions on the future organisation, education and practice of occupational therapy. What is original in this work is that it is an attempt to understand the process of professionalisation in a social context. It is based on the premise that refinements and changes occur as individuals and groups decide future action based on their interactions with one another.

Structure of Thesis

A literature review is presented first providing a link between existing knowledge and the study. Methodological considerations are then discussed followed by an outline of the methods used to answer the research question. The findings are

then revealed with a discussion at the end of each chapter for ease of reading. The thesis ends with a short critique of the study and then the conclusions and recommendations are set out.

INTRODUCTION

The first chapter is an introduction to the study. It discusses the background of the study, the aims and objectives, the scope of the study, the significance of the study, and the structure of the thesis. The second chapter is a literature review. It discusses the theoretical framework of the study, the empirical studies related to the study, and the gaps in the literature. The third chapter is a methodology chapter. It discusses the research design, the data collection methods, and the data analysis methods. The fourth chapter is a results chapter. It discusses the findings of the study. The fifth chapter is a discussion chapter. It discusses the implications of the findings, the limitations of the study, and the recommendations for future research. The sixth chapter is a conclusion chapter. It summarizes the findings of the study and provides recommendations for future research.

The study was conducted in a qualitative manner. The data were collected through interviews and focus group discussions. The data were analyzed using thematic analysis. The findings of the study are presented in the results chapter. The implications of the findings are discussed in the discussion chapter. The limitations of the study are discussed in the discussion chapter. The recommendations for future research are provided in the conclusion chapter.

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CHAPTER 2

LITERATURE REVIEW

This chapter explores the history of professions and draws out the main theories, which are critiqued and synthesised to form the conceptual framework of the study. Databases used included BIDS, Medline, Embase, CINAHL, PsycINFO, DH-Data, and BNI using search words, profession/professionalism/professional meshed with history, practice, knowledge, attitudes, status, autonomy, accountability, ethics, education, competence, quality, jurisprudence, legislation, malpractice, inter-professional relations, service ideal, socialisation. There has been less interest in research about professions since the 1980s, which has been attributed to a shift in emphasis from how professions were structured and what function they served to how such occupations have secured a privileged position in society (Macdonald 1995). Much of the literature, therefore, is historical but more recent work has been included where appropriate. To place it in context a short history of occupational therapy is presented in the light of the general discussion of professions.

HISTORICAL PERSPECTIVE OF PROFESSIONS

The term 'profession' is fraught with semantic and definitional dispute, not least because it is used both as a noun and an adjective. In the past, a profession was seen as a genteel alternative to a 'job' or 'occupation'. Now there are semi-professions, quasi-professions, remedial professions, paramedical-professions, sub, auxiliary, marginal, liberal, and learned professions (Millerson 1964a): an indication of the extent to which occupations are prepared to go to align with the term. Moline (1986) drew attention to the etymology of the word, which was traced to *profiteor*, to 'acknowledge openly', 'confess', 'avow', and 'declare oneself to be'. Bennett & Hokenstad (1973) who noted its medieval origin in professing or making vows to the Church made a similar point. In so doing, the expectations of duty and service were clearly identified with professions from a very early stage. A professional asks to be trusted, based on a vow or a code of ethics and their motto should be *credat emptor* (let the buyer trust) according to Hughes (1963) rather than the *caveat emptor* (let the buyer beware) associated with business. This spirit was captured in antiquity with the Hippocratic Oath,

I will use treatment to help the sick according to my ability and judgment, and never with a view to injury or wrong-doing....Into whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrong-doing and harm, especially from abusing the bodies of man or woman, slave or free (Hippocrates, in Moline 1986: p506).

Larson (1977) provided an historical examination in her analysis of the professions in relation to the market and class systems. Briefly, in medieval times, law, medicine and the ministry, the classical professions, were under the

tutelage of the Church, which enhanced the mystery surrounding their esoteric knowledge. Between the eleventh and thirteenth centuries they had a closer association with universities, where knowledge of Latin distinguished them as 'learned' and gave them an association with elite society. It was an education based on classical culture rather than practical skill. In contrast, people such as tradesmen, scribes, spectacle-makers, apothecaries and barber-surgeons, were associated with and managed by craft guilds. Their skills were acquired through an apprenticeship with a master who could be anywhere on the social scale. Thus, Larson (1977) concluded, social position was defined by an individual's work. Similarly, in his consideration of 'self', Hughes (1981) made an association between work and social identity.

Work choices, therefore, provided the impetus for groups to improve their status. For example, from the sixteenth century, the Royal College of Physicians had monopolised license to practice in London but elsewhere, medical practitioners from the lower branches, such as apothecaries, were increasing. They worked in the provinces in very competitive markets, outside the jurisdiction of the official professional body. By the seventeenth century, London physicians, through elite practices, were very wealthy but apothecaries were also practicing medicine and distinguishing themselves from shop-keeping druggists. By the eighteenth century, although they had not matched the position of physicians, apothecaries were recognised as genuine medical practitioners and their status had risen. The craft guilds eventually declined but some occupations survived and evolved towards the modern constitution of the professions, which started to develop in nineteenth century England. Spectacle makers became optometrists and apothecaries became pharmacists, for example (Larson 1977).

Elliott (1972) identified two distinct strands of professionalism, which were evident in the nineteenth century. On the one hand he noted traditional 'status professionalism' which was concerned with a right to social position rather than the performance of a specific function. On the other hand 'occupational professionalism' referred to the idea that changes in knowledge and economic and social organisation created opportunities for occupations to provide a skill needed by society. He recognised though, the complexity of any analysis in that, whilst modern professions are based on expertise, they have also drawn, sometimes quite heavily, on the ideology of the older traditions.

According to Larson (1977) professional advancement was primarily achieved by the capacity to claim a unique and esoteric skill which promised prestige, social recognition, authority and respect. Skilled expertise and knowledge based services became significant to society following the Neolithic Revolution. When settled agriculture developed and the struggle for survival became more organised, knowledge was unified, which created the opportunity for the cultures of arts and sciences to emerge; bureaucracy, organised religion, philosophy, mathematics, astronomy, medicine and law (Perkin 1996). The Renaissance (early fifteenth century), the Reformation (early sixteenth century), and the

Enlightenment (early seventeenth century) all allowed independent thinkers and innovators to flourish in Europe (Macdonald 1995; Perkin 1996). Polyani (1957) called this 'the great transformation'. The Industrial Revolution of the eighteenth century onwards, introduced enormous changes to the way that people lived. Piped water, gas and electricity and so on needed to be supplied by people with specific knowledge; a free market had been created and occupations, from engineers to quantity surveyors, proliferated (Perkin 1996). Freidson (1984) was of the opinion that many people have the ability to learn all of these skills but there is insufficient time in one person's lifetime to undergo the training necessary to learn and sustain competence in every type of skill necessary. Therefore, unless someone lived a very simple life indeed, reliance on the expertise of others had to be established.

During the Neolithic Revolution, when any excess of food could be stored, the dominant elite were slave owners or feudal lords who achieved their position of wealth and plenty through warfare and conquest and exploitation of those who had produced the surplus (Perkin 1996; Macdonald 1995). Thus, to take a Marxian view, there were always groups who tried to dominate others. Perkin went on to argue that, whilst pre-industrial society had been dominated by landlords who controlled the scarce resource of agricultural land, industrial society was dominated by capitalists who controlled the scarce resource of human beings in factories. Yet in post-industrial society professionals have grown in power and influence, not by revolution but by the 'seduction' of knowledge achieved by advanced education and experience. Furthermore, the scarcity of the resource of expertise allowed them to claim high remuneration (Perkin 1996). Larson (1984) also pursued this theme. In her view, professional leaders realised the importance of knowledge as 'a non-coercive form of power' and built an ideology of 'monopolized expertise' based on the traditional ethic of craftsmanship, emphasising the intrinsic value of work and an ethic of community, emphasising duty. Post-industrial professionals appealed to the state for protection against the free market by seeking support for producing members whose competence was superior to others. Thus, expertise became a commodity and the state entrusted professional 'experts' to define the needs of society and the means required to serve them, making them powerful groups.

Professional Associations

For Goode (1960) the two primary considerations for the newer professions were the knowledge base and service or 'collectivity orientation' but the formal associations were paramount in bringing changes in power, income or prestige. Central to Larson's (1977) work was the importance, for the modern professions, of specialist knowledge and certification of competence, as opposed to birth or patronage. Formal education with practical training took the place of apprenticeship. The organisation of qualifying associations facilitated the process by introducing better standards and improved status. Physicians had helped to set

a precedent when, following the split from the Church, the Royal College of Physicians was formed.

To curb the audacity of those wicked men who shall profess medicine more for the sake of their avarice than from the assurance of any good conscience.

(Royal College of Physicians 1518 quoted in Carr-Saunders & Wilson 1933: p 298)

Carr-Saunders & Wilson (1933) traced the history of professional associations throughout the sixteenth and seventeenth centuries when they were regarded as exclusive, lazy organisations resistant to reform, typifying the worst of 'professional men'. Subsequently occupational groups formed study societies to discuss work issues in an academic way and from these a new form of professional association developed. Members wanted to distinguish and protect themselves from less skilled others who were doing the same job. This was achieved by limiting admission to those who could show evidence of competence. Prestige was bestowed to members of such associations. Later, the emphasis changed from respectability and status to protection of interests such as high remuneration. In the opinion of these two sociologists however, although this motive was present, the most important function of professional associations was to raise standards of work. This helped to distinguish the professions from the trade union world and to stipulate clearly defined boundaries of work, which gave them stability in society (Carr-Saunders & Wilson 1933). The Pharmaceutical Society of Great Britain, for example, was formed in 1841, with these functions in mind (Millerson 1964a). Millerson's (1964b) work led him to believe that, from the nineteenth century, occupations established associations and introduced examinations with the specific aim of improving standards and status. He identified them as the means by which individuals were made to conform to specific occupational norms. Associations contained the language and symbols of the profession and since only members understood the meanings of the symbolic system, this too, separated professionals from non-professionals (Hall 1975). Thus, workers were offered the opportunity of gaining status and social mobility through professional associations.

The Rise and Fall of Professions

Such was the increase in the numbers of occupations striving for professional status in the nineteenth century that Goode (1960) pronounced 'an industrializing society is a professionalizing society'. He pointed out that whilst many occupations did rise, some declined: it is a zero-sum game. The ministry, for example, no longer has the status it was once accorded as theological knowledge became less relevant to the problems of modern society and social workers, psychiatrists and community workers took over the personal-service market (Turner 1985). In more recent times remedial gymnasts ceased to exist when they merged with physiotherapists in 1988 (Council for the Professions Supplementary

to Medicine 2001). Struggle and competition is involved, with professions behaving defensively at the threat of encroachment on an identified area of work. This stance was aptly demonstrated in Goode's (1960) critique of the relations between sociology, psychology and medicine when each used competitive strategies as they moved towards professionalisation. It was thus viewed as a dynamic process.

State Sanction

According to Carr-Saunders & Wilson (1933) the state intervened in the Middle Ages with vocations, which later became professions, to ensure competence and discipline, but the mechanisms employed were clumsy and ineffective and were discarded. Centuries later, there was an expansion of service professions (Wilding 1982). The government enacted that there should be a list of practitioners and that only people of proven competence should get on the list. The most important characteristic common to all of these professions was that the service must be vital or fiduciary or be concerned with public safety (Carr-Saunders & Wilson 1933).

Freidson (1994) developed the idea of post nineteenth century occupations competing with each other in an open market, arguing that both in England and America they made use of the predominant laissez-faire philosophy. With the state playing a passive role, competing occupations organised their own training and qualifying associations and sought state support to provide shelter from the open market. State sanctioned shelter could only be justified in special circumstances. The ideologies of specialised knowledge and disinterested dedication, provided by the traditional concept of status profession, and the idea that training courses, validated by the professional association, were assumed to produce practitioners of equal competence, persuaded the state to give the profession a monopoly of work (Wilding 1982; Freidson 1994).

THEORIES OF PROFESSIONALISM

Such was the expansion of professionalisation within the labour market that it attracted a great deal of interest from social analysts whose theories formed a number of different strands.

Functionalist Theories

Functionalist theory was predominant within the sociology of the professions prior to the 1960s. Early sociologists such as Emile Durkheim considered that the function of the professions was to encourage social cohesion by creating a moral order to counter the lawlessness of industrial society. He viewed society in terms of having a moral basis that functioned at different levels. He described, what he termed 'moral particularism' which,

Has no place in individual morals, makes an appearance in the domestic morals of the family, goes on to reach its climax in professional ethics, to decline with civic morals and to pass away once more with the morals that govern the relations of men as human beings, (Durkheim 1957: p 5).

He judged that professional ethics stemmed from a particular system of morals that a group wished to protect by becoming organised in such a way that the governance of individuals' behaviour was strictly regulated. This gave professions a moral authority. In business no such organisation existed: no professional ethics and, by implication, no moral restraint. In Durkheim's opinion, there was a danger that this lack of moral influence would lead to a state of anarchy. Therefore, the professions had a duty to act as a moderating influence on society.

This view was similar to that of other sociologists such as R.H. Tawney (1921) who regarded professionals as being on a higher moral plane, choosing a way of life that allowed them to unselfishly serve the public. Carr-Saunders & Wilson (1933) viewed the professions as stabilising elements in society. They placed the ancient professions of law and medicine at the epicentre around which others could be judged. The distinguishing features which identified a profession's approximation to the centre included: a specialised intellectual technique which allowed it to provide a service to the community, prolonged training, a sense of responsibility for ensuring that competence was tested and a concern for the honour of the practitioners. Barber (1963) defined professionals in similar terms. The most powerful strategy imposed, for testing competence and the enforcement of standards of conduct, was the historically rooted aspiration for the establishment of a professional association.

Talcott Parsons acknowledged the importance of professions in social structure. He argued that,

The professional type is the institutional framework in which many of our most important social functions are carried on, notably the pursuit of science and liberal learning and its practical application in medicine, technology, law and teaching, (Parsons 1939: p 48).

The consensus of opinion at the time was that members of the business world cared little for the interests of others whilst professionals devoted their lives to service: there was a contrast between egoistic and altruistic motives. However, Parsons was more circumspect. In his examination of the long-held belief that the distinction between professions and business centred on the absence or otherwise of self-interest, he concluded that this may have been an exaggeration. Both business and professional worlds were found to have much in common. He believed that social pressures, rather than a belief in the importance of the social functions of professions, drove them as in business, to be rational and functionally specific (by which he meant having technical competence limited to

a particular field of knowledge and skill). Professionals and businessmen each strove for success in terms of objective achievement and recognition. The difference, he argued, lay in the different paths to these goals, which were determined by the location of an occupation within a social structure. In business the goals were directed towards expansion whereas medicine aimed to increase the number of cures for patients (Parsons 1939).

Whilst important from a historical point of view, work on the functional attributes of professionals and businessmen has since attracted criticism on empirical grounds as being inaccurate (Dingwall 1976); that is, the reality of professional work often failed to match the official image. Johnson (1972) argued that functional analysis neglected to take account of history, when certain professional groups used their power to secure favourable circumstances. Witz (1992) thought it misleading to focus on the success of class-privileged, male actors at a particular point in history as 'the paradigmatic case of profession'. Similarly, Freidson (1994) considered it inappropriate to treat professions as a generic concept, regarding it as 'a changing historic concept, with particular roots in an industrial nation strongly influenced by Anglo-American institutions'.

Trait Theories

Other writers assumed that there must be a structure of identifiable characteristics that made professional work different from that of other occupations. Flexner began the work in 1915 having identified six criteria.

Professions involve essentially intellectual operations with large individual responsibility; they derive their raw material from science and learning; this material they work up to a practical and definite end; they possess an educationally communicable technique; they tend to self-organization; they are becoming increasingly altruistic in motivation, (Flexner 1915: p 581).

These criteria led Flexner to eliminate plumbing as a profession because the intellectual element was missing, banking because business experience or common sense was required rather than a scientific base and social work because the content of the work was too diverse and there was no definite field of work. Physicians succeeded the test. Ultimately though, the attribute that Flexner thought surpassed all else, was professional spirit.

The unselfish devotion of those who have chosen to give themselves to making the world a fitter place to live in, (Flexner 1915: p 590).

The trait theorists were at their height in the 1960s. Goode (1960) offered further analysis of the features that might be used by associations to professionalise an occupation. In so doing he identified a continuum of professionalism against

which he thought it possible to judge the position of an occupation. The traits included:

1. The profession determines its own standards of education and training
2. The student professional goes through a more far-reaching adult socialisation experience than the learner in other occupations
3. Professional practice is often legally recognised by some form of licensure
4. Licensing and admission boards are manned by members of the profession
5. Most legislation concerned with the profession is shaped by that profession
6. The occupation gains in income, power, and prestige ranking, and can demand higher calibre students
7. The practitioner is relatively free of lay evaluation and control
8. The norms of practice enforced by the profession are more stringent than legal controls
9. Members are more strongly identified and affiliated with the profession than are members of other occupations with theirs
10. The profession is more likely to be a terminal occupation. Members do not care to leave it, and a higher proportion assert that if they had it to do over again, they would again choose that type of work. (Goode 1960)

Greenwood (1965) in his classic statement put forward five attributes:

1. Systematic theory
2. Community sanction
3. Authority
4. An ethical code
5. A professional culture

Wilensky (1964) was interested in process and identified a sequence of historical steps towards professionalisation:

1. The emergence of a full time occupation
2. The establishment of a training school
3. The founding of a professional association
4. Political agitation directed towards the protection of the association by law
5. The adoption of a formal code

The overlap within these lists was given some order when Millerson (1964b) collated 23 attributes of a profession after studying 21 authors and condensed the essential elements:

1. A profession involves a skill based on theoretical knowledge
2. The skill requires training and education
3. The profession must demonstrate competence by passing a test
4. Integrity is maintained by adherence to a code of conduct
5. The service is for the public good

6. The profession is organised

Johnson (1972) noted that no single item was accepted, by all of the authors, as being essential to a profession, no two contributors were agreed that the same combination of elements could be taken as defining a professional occupation and that nine of the elements were suggested only once.

Using the trait approach Etzioni (1969) analysed nursing, the remedial therapies and social work and classified them as being 'semi-professional'. In his opinion, their further progress was hindered because they lacked clearly demarcated scientific knowledge bases; they were based on skills rather than knowledge and they had not achieved self-regulation. To a large extent they were involved with communication rather than the application of knowledge and they were not involved in matters of life and death: thus their services were less important. Other inhibitory factors included the predominance of women in these occupations and the tendency for them to be based within bureaucratic structures.

In 1969 Hickson & Thomas produced a Guttman scale measuring degrees of professionalisation. Data were obtained from a sample of 43 qualifying associations and the authors acknowledge therefore, that the study was restricted to those occupations sufficiently professionalised to have an association. Fourteen scale items were selected from the literature including training and education, competence tested and so on. For statistical reasons, 'skill based on theoretical knowledge' and 'altruistic service,' two of the most often reported traits, were removed from the scale. After analysis, the Royal College of Obstetricians and Gynaecologists came top of the scale with a score of 13, the Institution of Works Managers scored 0, whilst the Chartered Society of Physiotherapists scored 7. Thus it could be concluded that in 1969 physiotherapists were half way up the professionalisation ladder. The scarcity of scales though, in ensuing literature, perhaps indicates that this positivistic approach has not been helpful in the study of professions.

The trait approach has been criticised on a number of grounds. Dingwall (1976) regarded the logical outcome of the approach to be that a profession was nothing more or less than what a sociologist said it was. Larson (1977) commented that, 'ideal-typical constructions do not tell us what a profession is, only what it pretends to be', whilst Johnson (1972) considered it a mistake for trait theorists to have accepted the professionals' own definitions of themselves. Johnson (1972) and Wilding (1982) attacked the assumptions that there was a true profession from which traits could be extracted and that professional work was different. They considered that traits should be subjected to greater analysis. Johnson was critical of the lack of theoretical underpinning that might have examined the relationship between the traits: whether or not a direct causal relationship between systematic theory and authority could be proved, for instance.

Johnson continued to highlight the problem of distinguishing between aspects of the ideology of the professions, such as the service ethic, and whether or not practitioners had fully adopted this orientation. Traits were drawn from analysis of a few professional bodies and were influenced by Anglo-American culture at a particular point in history. Additionally he thought that the general social conditions under which professionalisation occurred were ignored. Neither was there any discussion of the fact that the clientele were important in affecting professional development for example, the low status of the child was considered a factor in determining the low prestige of teachers. But his most fundamental criticism of both the trait and functionalist approaches was that they did not offer definitions of occupations at all 'but specify the characteristics of a peculiar institutionalised form of occupational control' (Johnson 1972). On the other hand, whilst accepting the legitimacy of these criticisms, Freidson (1994) thought that it was not the fact that a definition consisted of traits that was the problem, since such errors could be addressed but it was still necessary to explain, in some way, what constitutes a profession. Although critical of the approach, Dingwall's (1976) work with health visitors produced a list summarising the ways in which they considered themselves to be professional. The results bore many similarities to the traits, including having formal qualifications, self-regulation and a discrete body of knowledge. This perhaps reflects the extent to which historical perspectives have influenced aspirant professionals, and continue to do so, despite much of the work being dismissed.

Interactionist Approach

The school of symbolic interactionism, which developed in America, offered an alternative approach to functionalism. Essentially, it derives from the work of George Mead (1863-1931) but Everett Hughes (1897-1983), based in what came to be known as the 'Chicago school of sociology' was pre-eminent (Dingwall & Lewis 1983). There has been no clear definition of symbolic interactionism but Herbert Blumer outlined three basic premises:

1. Human beings act towards things on the basis of the meanings the things have for them. 'Things' may be physical objects such as a tree; other human beings such as a friend; institutions such as a school; guiding ideals such as honesty or activities of others such as their requests etc.
2. The meaning of such things, or objects, is drawn from the social interaction between people. The actions of others help to define the thing for a person.
3. These meanings are managed and modified through a continuous and interpretive process. Through a process of self-interaction an individual selects, checks, suspends, regroups and transforms the meanings in a given situation, which subsequently guides the action to be taken in that situation. (Blumer 1969).

This approach considers that human society is made up of people engaged in action. Individuals are constantly developing lines of action in the numerous

situations they encounter. They may act singly, collectively and they may act on behalf of an organisation or group. They are involved in a process of interaction in which they fit their own actions to those of others. This process consists of indicating to others what to do and interpreting the indications made by others. When an individual sees a person waving in his or her direction, for example, a process of reflection takes place to allow the individual to identify whether this gesture was intended as friendly, hostile, beckoning etc. Once the meaning of the other's action is interpreted, this determines the response to the action. This view of human action applies also to groups, institutions or organisations. From this standpoint, culture (customs, traditions, norms, values) is drawn from what people do and social structure (social position, status, role, authority, prestige) refers to relationships rooted from the ways in which people act toward each other. People live in worlds of meaningful objects that are continuously being re-appraised. But people live in different worlds and therefore approach each other differently and guide themselves by different sets of meaning (Blumer 1969). 'Profession' therefore, can be regarded as an object, which can be examined in terms of what professional people do and how they act towards each other.

It is easy to see why the symbolic interaction approach would be attractive to sociologists studying the culture of professions and professionalism. Becker et al's *Boys in White* (1961) was an early example. This study stemmed from an interest in the changes that were assumed to occur in those undergoing professional training. Medicine was selected as a classical example of a profession that had increased the length of training in order to convince society of the competence of those who had achieved the status of physician. Using participant observation as the main method of investigation the authors conducted a cross-sectional study of students undergoing four years training in the University of Kansas Medical School. Change was considered as an everyday process and, working with a theory based on the concept of symbolic interaction, data were gleaned from the first hand experience of the students. Attention was paid to the organisational features of the school and how it affected values, attitudes, and perspectives toward medicine and medical practice as the students progressed through their training.

Both school and students shared the same goal; producing good doctors, but the cultures that influenced the process were at deviance. The students were concerned with the day to day details of getting through medical school whilst the school was interested in preparation for continued education once the basics were learned. First year students had picked up their knowledge of medicine from the lay culture (experience of being patients, from films and so on). Doctors were hard working and selfless in their efforts to help the sick. The students, collectively, equated a good doctor as one who had 'learned it all'. This, however, involved a phenomenal amount of material. As the cohort interacted, the most cohesive, structured and socially homogenous group were those who thought of themselves as 'students' rather than 'medical students'. They had the greatest influence on the class as a whole to change the direction of effort towards

learning what was thought may appear in examinations (Becker et al 1961). Through this method the analysts were able to show evidence of cynicism among medical students, whose perception of patients was based on what could be learned from them. The service orientation or altruism beloved of the functionalists was a more complex issue than a statement of fact and was set aside until after qualification.

Power Theories

A shift in emphasis developed within the sociology of the professions after the 1960s, partly fuelled by the symbolic interactionist approach. Until that time the professions were considered valuable and necessary and most researchers were,

Inclined to see professions as honored servants of public need, conceiving of them as occupations especially distinguished from others by their orientation to service the needs of the public through the schooled application of their unusually esoteric knowledge and complex skill. (Freidson 1994: p 13).

In the 1970s and 1980s the position, roles and functions of welfare professions were subjected to examination from a more educated and critical society, fuelled by a number of hospital scandals (Foster & Wilding 2000). Writers examined professionalism as an ideology, which was aimed at gaining status and privilege. 'Power' became an important component of much of the work, Eliot Freidson being a protagonist. In the *Profession of Medicine* (1970), for example, he studied doctors in America and Britain and the ways in which they had successfully achieved autonomy of their work, resisted any outside control, although self-regulation was weak and were able to dominate other occupations. Structures such as the code of ethics were viewed as important devices for persuading the state and the public to support the profession since its members must be 'ethical'. The systematic theory, considered so essential, was found under scrutiny, to have less bearing on the work as it really was, than had been claimed.

Medicine aimed for dominance which not only involved control over the work situation and professional autonomy but also occupational sovereignty over neighbouring occupations (Turner 1985). Medicine controlled these occupations in a number of ways, one of which was to force them to work in subordination. Midwives, for example, were prevented from achieving autonomy and did not develop into gynaecologists, because they remained under the subordination of medicine (Goode 1969). The title 'paramedical professions', was created to give dignity and pride to workers who were part of a division of labour who were subordinate to, organised around and controlled by the real profession of medicine (Freidson 1970). They gained state registration but this did not bring complete self-government for such workers. They developed within established boundaries of competence and were denied the freedom to diagnose and therefore could not achieve full autonomy in the performance of their work (Larkin 1983).

Johnson (1972), another advocate of the power approach, placed great importance on the diagnostic relationship, among some of the service professions, as a means of control over allied occupations. Doctors had their expertise taken for granted because all treatment stemmed from their diagnosis, which placed them in an authoritative role. Having established authority with regard to patients, medicine also gained control over allied health professionals who carried out treatment only in respect of the diagnosis and referral from a doctor. Turner (1985) highlighted two other means of medical domination in relation to allied occupations: limitation and exclusion. Dentists and optometrists were limited to working on a specific part of the body while pharmacists were restricted to a specific therapeutic technique. The case of chiropractors is an illustration of exclusionary practice by medicine, which, until recently was successful in denying their acceptance within orthodox healthcare. Orthopaedic surgeons and podiatrists are currently in conflict over the title 'consultant'. The British Orthopaedic Trainees' Association argues that it takes a doctor as much as 15 years to become a consultant after completing a five-year medical degree. So any patient referred to a 'consultant podiatric surgeon' might be misled into believing they are seeing a leader in their field. Podiatrists counter that orthopaedic surgeons took no interest in feet until they came along. There is no legal protection of the title and the term suggests only that they are experts in feet. Nevertheless orthopaedic surgeons are trying to make the title exclusive to medicine in an effort to re-assert their authority (Hawkes 2004).

Johnson (1972) was interested in the ways in which powerful, entrenched occupations; governments or academic institutions influenced the organisation of an occupation and the content of practice. Taken from a British perspective, he introduced the idea that the distribution of power in society changed over time, which affected professionals' relationships with clients. He thought that the specialised skill of a professional and the absence of it in the client resulted in social distance which created potential for autonomy but also uncertainty and therefore tension in the relationship between producer and consumer. Drawing on the historical perspective and clearly from the Marxian tradition, he identified three methods of resolving the tension in the producer/consumer relationship:

1. Collegiate Control

In this case the producer defines the needs of the consumer and the way in which those needs are served. Guilds in medieval Europe and occupational associations in the nineteenth century were responsible for organising work in this way. Professionalism was identified as a sub-type of collegiate control, which helped to legitimate the power of the producer to exercise authority over the consumer. Lengthy training, socialisation to ensure a shared identity, a code of ethics and the process of mystification making work difficult to be evaluated by non-members, were all mechanisms through which an image of moral superiority was expressed.

2. Patronage

The consumer defines the needs and the ways in which they should be met. This occurred historically with craftsmen, architects and doctors being governed by the aristocracy. Similarly, accountants can be beholden to corporate business in modern society.

3. Mediation

A third party mediates in the relationship between producer and consumer. State mediation of welfare provision is an example, in which the state defines what the needs of society are and how they should be met. It was however, acknowledged that variations may occur as in the case of health where the state decided who was to receive medical care but doctors remained powerful in determining delivery of service. Johnson continued to examine the relationship between the professions and the state, and the ways in which each may benefit. The professions were considered useful to the state because of their value in the maintenance of particular economic and social systems. In return the professions needed the state to enforce privileges such as monopoly of service, power to control entry to the profession, legal protection of title and peer group control of professional work (Johnson 1972). Medicine and therefore by association, allied health professions are a mixture of collegiate and mediation types of control.

Wilding (1982) discussed the nature and extent of professional power in five areas;

1. Power in policy making

Once again medicine is cited as an example. Klein (1989) pointed out that in the 1950s policy makers trusted the medical profession entirely to determine the content of health policy. The role of the British Medical Association in the creation of the National Health Service (NHS) in 1946 ensured that conditions were favourable for medicine. The ideas of salaried service and regulation by local government, for example, were eliminated. Similar influence was exerted during the reorganisation of the NHS between 1968 and 1974. Wilding does not argue that professionals should not be involved in policy making but that it can be self-serving. Professional, rather than public interests are served; services are organised around professional skill rather than the needs of the client and powerful professions such as doctors are able to dominate decisions. He drew attention to the fact that the bias towards highly technical aspects of medicine is unlikely to be of benefit to the elderly, the predominant population in hospitals.

2. Power to define needs and problems

There is an acceptance in society of the professions' definitions of needs and problems but there is an inherent danger that those needs are engineered to fit in

with professional skills, the medicalisation of pregnancy is an example. Thus, demand for more professionals is generated.

3. Power in resource allocation

Until recently doctors had substantial control over NHS resources, particularly in purchasing equipment, allocation of staff, prescribing, sending patients for tests, examinations or recommending surgery and so on.

4. Power over people

The expertise and ethicality attributed to professions, places them in an authoritative position relative to their clients. When professionals work in public organisations, which are monopolies, such as NHS hospitals, this reduces consumer choice. Hugman (1991) considered this power dimension and examined the ways in which health professionals had power over patients. He found that they also exercised power within their own occupations in the way that senior staff members treated juniors. He also argued that the power exercised by a nurse or therapist was relative to the gender of the service provider and user. A male nurse had greater power when dealing with a female patient, for example. Feminists, naturally, accorded with this view and accused the medical profession of attempting to control female patients for patriarchal reasons (Dale & Foster 1986).

5. Control over area of work

Central to the ambition of gaining control of a particular area of work is self-regulation. The argument is that only members are able to understand and govern a profession. Traditionally professional associations were responsible for the discipline of members, developing sanction mechanisms and a code of ethics to control behaviour both on and off duty (Millerson 1964b). Incumbent with this view is that the professions should also control entry to, and training of, professional occupations (Wilding 1982).

Gender and power

Hugman (1991) was interested in power within caring professions, particularly the power of medicine in relation to the allied professions. He drew attention to the distinction between 'caring about', and 'caring for'. Doctors were solely concerned with 'caring about' but nursing, occupational therapy, physiotherapy, and so on tended to combine both adjective senses of the word. These occupations developed in the nineteenth century when circumstances made it possible to claim a skill related to caring, which allowed women to enter professional life. In doing so these professions had, in fact, removed this work from family and others who had done it informally, and at the same time 'took over' the carer as much as the person being cared for. Yet, their professional

status has been regarded as incomplete because it has been perceived as less expert 'caring for' women's work which could be done by anyone.

Witz (1992) also looked at gender relations and the power of patriarchy within the professions. Historically, women were denied access to education, which precluded them from practicing within a profession and created them as a class of 'ineligibles'. In a clear reference to Goode's (1960) work on struggle and competition she outlined various strategies, which were used to counter what she called exclusion or demarcation tactics (and Turner (1985) called exclusion and limitation) used by (mostly male) doctors in dominating other health workers. Women became involved in a 'two-way exercise of power', in which they tried to resist the demarcation of some aspect of work from the dominant profession, and at the same time sought to consolidate their own position. Midwifery for example, was a demarcated area of doctors' work and while resisting medical control, midwives simultaneously excluded subordinates through state registration and protection of title, tactics often referred to as 'closure' or 'dual closure' in this case (Witz 1992). Social closure is a Weberian idea in which social groups attempt to close access to an occupation, to its knowledge, education, training and jobs whilst usurping the privileges of other groups and aiming for upward social mobility of the whole group (Macdonald 1995). Power struggles have occurred between professions as well as between workers within the same discipline. An internal form of closure may be created when an occupation develops sub groups of workers, often called 'assistants', aides or 'helpers' and specialists rather than generalists (Hugman 1991).

The Professional Project

According to Macdonald (1995) some writers have included Magali Larson within the power approach but in his opinion, her neo-Weberian line of analysis concerns itself with power but only in the sense that it deals with conflict, the outcome of which results in some group being superior. Larson used the interactionist position as a base and incorporated the views of Weber to introduce the notion of professional markets. To reiterate the earlier discussion, she detailed the ways in which, through the course of history, professions have become positioned in social order, created a market for their services and gained status with respectability. The creation of modern professions in the nineteenth century provided the middle classes with an opportunity to gain status through work but they had to compete with those who had become professional by virtue of birth and patronage. The response was to guarantee competence based on education and certification as distinct from the social superiority of traditional, elite professionals. Specialist knowledge became an opportunity for income. A professional market was generated, for which an identifiable 'commodity' had to be produced. It was essential that the professionals delivering this commodity were to be adequately trained and socialised so as 'to provide recognizably distinct services for exchange on the professional market'. Great emphasis was placed on systematic training, located in professional schools or universities, or

'the standardized and centralized production of professional producers'. Monopolisation, state protection, control of training, and control of entry to the profession were vital strategies in what was termed the 'professional project'. Her work concerned collective action and collective mobility, in that, through the upgrading of an occupation by the organisational efforts to control members, prestige was attached to both the professional role and the individual (Larson 1977). She emphasised the link between rank and file members and the elite of the profession but the nature of her work dealt primarily with the latter. For this reason, Macdonald (1995) considered that it would be beneficial for future researchers to collect data from individual members. This provided one of the motivations for my study.

The professions have received scant attention from researchers in recent times but Foster & Wilding (2000) have examined the change in the attitude of the state to welfare provision in the 1980s and 1990s when the Conservative government, under Margaret Thatcher, attacked the power and autonomy of these groups. They highlighted how the New Right criticised organisations such as the NHS for being unresponsive to patients because there were no incentives to put patients' needs first. They were considered to be wasteful of resources, self-interested and seemed to be accountable to no one. Inquiries following a series of health tragedies led to questions being asked of the effectiveness of self-regulation. In addition, industrial disputes damaged the altruistic image of the professions, which led to such moralistic claims being treated with derision. They were seen as inefficient as a result of their state protection from market forces and their claims for expertise did not bare scrutiny. Management was seen as a superior alternative to delivering effective social policy. The aim of Thatcherism was to bring welfare provision under control, to improve consumer power, promote greater professional responsiveness and increase efficiency. First the *Griffiths Report* (Department of Health 1983) and then *Working for Patients* (Department of Health 1989) introduced management structures, which curtailed the powers of consultants to organise their NHS work. An internal market system was created which caused a purchaser-provider divide. Managers were involved in the allocation of merit awards for consultants whilst general practitioners became accountable to Family Health Service Authorities. GPs were required to meet targets for vaccinations etc within specific budgets. In contrast, the rights of health service users were strengthened by the introduction of the *Patient's Charter* (Department of health 1991) (Foster & Wilding 2000).

The current Labour government has continued to apply constraints to the professions, with an emphasis on quality of service provision. Managerial accountability and performance management is intrinsic to the White Paper *The New NHS: Modern, Dependable* (Department of Health 1997). All health and social care staff are now influenced by the structures set out in the government strategy *A First Class Service* (Department of Health 1998) including National Service Frameworks (NSF), the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI), now re-named the

Commission for Healthcare Audit and Inspection (CHAI). These structures are all aimed at the promotion and maintenance of high standards of professional practice. The concept of 'clinical governance' has been introduced, facilitated by patient and public involvement in healthcare, audit, staff education and training, clinical effectiveness and risk management. The aim is to strengthen systems of professional self-regulation, which run parallel to managerial systems of quality control (Foster & Wilding 2000). The quality of work within the NHS is being much more stringently monitored by outside agencies, the inference being that the government continues to distrust self-regulation.

Foster & Wilding (2000) concluded that whilst it was right to curtail the power and lack of accountability of the professions, politicians may have gone too far, hitting them so hard that some of the most beneficial aspects of professionalism may be in danger of being lost. A reduction of autonomy may lower morale, motivation and commitment. As professional work is more managed, audited and inspected it may simply serve state purposes and result in adequate, rather than excellent service. Promotion of consumer power makes the relationship between professionals and service user more adversarial. In a compensation culture this may encourage defensive practice. Similarly, in the world of academia, Nixon (2001) challenged the notion that debate about academic professionalism should be conducted in terms of 'standards' and 'outcomes'. In his opinion this has constrained professional values and restricted the freedom of academics to focus on issues that affect society as a whole, the public debate on higher education, for example.

Finally, Foster & Wilding (2000) argued that the service ethic, the principle of colleague control and the commitment to high-quality work are aspects to be cherished and should be built on rather than be treated with cynicism. The reforms have been radical, requiring adjustment in the relations between politicians, professionals, managers and service users, which inevitably creates tension, which can be evidenced by a cursory look at the national press. The charity, Cancer Research UK, for example, asked for exemption from regulations in the Data Protection Act because medical research was being threatened by new rules to make patients' records more confidential (Revill 2003a). One of the consequences of medicine losing some of its power to decide health policy seems to be that it has given drug companies the opportunity to create new diseases such as female sexual dysfunction, male menopause and attention-deficit disorder all of which require lucrative drug treatments (Revill 2003b). The British Medical Association (BMA) has been vociferous in resisting Agenda for Change (Department of Health 2003) contract changes, which aims to increase management control over career structure and restrict the amount of private work for junior consultants (Charter 2003). The BMA have also accused the government of eroding clinical freedom by setting up unrealistic targets, which has created a climate of fear and deception (Hawkes 2003). Such tensions are likely to generate counteractions from professionals; the early indications are that another sea change of opinion is occurring. Professions have faced attack before;

it is a long time since the Neolithic Revolution but the evolution of professionalism is not yet complete.

THE CONTEXT OF THE STUDY

Professional occupations then have been examined in terms of what function they serve and then the actions that have been undertaken in order to preserve an elevated position in society. The concept changes constantly: historical events being used to inform future action. The intent of this research was to investigate the professionalisation of occupational therapy, a lesser-known allied health profession that has struggled with its status. I wanted to explore the ways in which occupational therapists have constructed their world, historically, as professional people, how they interpreted professionalism on a day to day basis and how this was influencing the on-going process of professionalisation. What was the expertise being claimed, how was a market created, what actions did the professional association take, what has been done to ensure competence, how was state sanction achieved, and status gained, were all questions to be answered. In essence the study was an examination of the professional project for occupational therapy. The result would be an evaluation of the professional identity of occupational therapy in its present state. In particular, the investigation was guided by the idea that 'profession' could be construed as a symbol.

The Symbol of Profession

The power approach led to a fundamental shift away from how professions were structured towards how they act. Freidson (1994) considered that it was people in society who determined whether or not an occupation was a profession and in this sense it could be treated as a folk concept. He urged researchers to investigate how the state of profession was accomplished, the activities undertaken and what resulted as a consequence of the way in which professionals saw themselves and conducted their work. This is not a simple task as he recognised when he reported that 'there must be a number of folks and thus a number of folk concepts'. Similarly, he understood that professional members are themselves influenced by sociologists' view of profession as a concept. Becker (1977) too, thought that all layers of society ascribed the professional label to some and not other occupations. In doing so they usually applied a moral evaluation yet, he suggested that it was not necessarily clear to all that medicine, for example, was morally praiseworthy and plumbing not.

Hughes (1981) considered that work was one of the ways by which people judged themselves; it was an important part of social identity, of 'self' and people would try to present themselves to an audience in a favourable light. When work has a degree of status attached, the associated language is loaded with value and prestige judgements which, knowingly or not, people use to divert the scrutiny of others. In this sense 'profession' has become a term of value and prestige, a symbol of a desired status. When occupations strive for professional status therefore, they are attempting to change the public's conception of them and

members' own conceptions of themselves and their work. He came to the conclusion that, rather than trying to define 'profession' it was more useful to ask,

What are the circumstances in which the people in an occupation attempt to turn it into a profession, and themselves into professional people? (Hughes 1981: p 45).

Becker wrote in similar vein arguing that 'profession' is a highly valued collective symbol that should be regarded as those,

Occupations which have been fortunate enough in the politics of today's work world to gain and maintain possession of that honorific title, (Becker 1977: p 92).

He suggested that beneath the surface disagreements between theorists there was agreement on a set of interconnected characteristics, which symbolised a morally praiseworthy type of occupational organisation. Occupations striving to gain professional status will attempt to appropriate as many of the features of this symbol as possible. These characteristics are:

- Monopoly of a body of knowledge
- Control of training into professional practice
- Control of entrance to the profession
- Adoption of a code of ethics
- A service ethic

Finally, these features are absorbed into professional culture through a process of socialisation. The influence of the trait theories is self-evident but they are more complex than 'face value' characteristics. As subsequent discussions will reveal, each criterion is multi-faceted and generates action, which occupations regard as appropriate. However, individuals and collective groups or organisations are constantly undergoing transformations and interpretations of their perception of professions in the light of the actions of others. What is appropriate in one situation or at one time, may not be in another. There may or may not be harmony in the perception of any aspect of any characteristic. These complexities need teasing out in order to understand the situation more fully.

Taking this symbol as a base and following the advice of Macdonald (1995) and Freidson (1994) the endeavour of this research was to find out how occupational therapists accomplished the state of profession and, using data from members, investigate the results of such actions. To place the study in context it is necessary to outline the history of occupational therapy in the context of the foregoing discussion of professions.

The History of Occupational Therapy

Several writers have traced the history of occupational therapy but Paterson (2002) and Wilcock (2002) have produced very detailed commentaries. Occupational therapy is an example of an occupation that developed in the nineteenth century, having ideological roots in moral treatment, the arts and crafts movement, pragmatism and the mental hygiene movement. Quakers were proponents of moral treatment and founded the York Retreat in 1796, to support mentally ill patients in a healthy routine of domestic activities and outdoor exercise. The arts and crafts movement stemmed from the philosophies of John Ruskin (1819-1900) and William Morris (1834-1896) reacting to what they saw as the degradation of work due to industrialisation (Paterson 2002). The pragmatists believed that mind and body were intertwined. Theorists such as William James (1839-1914) and John Dewey (1859-1952) contributed to the formation of the concept of 'learning by doing' in occupational therapy (Reed & Sanderson 1999).

Early in the 1900s the psychiatrist and pragmatist, Adolf Meyer, a Swiss native who had emigrated to America, set out to improve the services for psychiatric patients. He used the mental hygiene approach, which encompassed the idea that many mental illnesses were preventable and that the use of gratifying occupation was fundamental to treatment regimes. The social climate of the time embraced the idea that work was morally superior to idleness and likely to produce desirable results for the individual and society. A balance between work, play, rest and sleep was considered essential for health and wellbeing (Paterson 2002, Wilcock 2002). It had been established that patients in psychiatric hospitals made better progress if they were occupied. However, there was also recognition that patients could be exploited by being coerced into undertaking monotonous and humiliating tasks. Therefore, whilst all work was good, some types were more appropriate than others (Hagedorn 1995). Meyer established the Phipps Psychiatric Clinic, which offered programmes including games, exercises, dancing, music and arts and crafts. Eleanor Clark Slagle had undertaken a course in Curative Occupations and Recreation in 1911 and went to work for Adolf Meyer who, having had his views on occupation confirmed, went on to establish occupational therapy in America (Wilcock 2002).

Meanwhile, in England, asylums for the mentally ill were using activity as part of moral treatment. There was also a growing perception that occupation could help people with long term physical disabilities: Sir Robert Philip pioneered occupation as therapy for people with Tuberculosis in Scotland (Paterson 2002). Women's suffrage and better educational opportunities led the way for women to find paid employment. Agnes Hunt, disabled herself, trained as a nurse and reflected on the contrast between her own circumstances, having grown up in a sheltered and financially secure environment, and those of 'crippled' children living in the slums of industrial society. She established Baschurch Home, Oswestry, in 1900 for the convalescence of 'crippled' children which, after the

employment of the orthopaedic surgeon Sir Robert Jones, developed into the Robert Jones and Agnes Hunt Orthopaedic Hospital. The use of occupation as treatment in curative workshops was established. The First World War resulted in a large population of young men who needed to be returned to the frontline. This led to the medical profession establishing occupational workshops to repair the mental and physical injuries of soldiers. Sir Robert Jones thought that the link between treatment and 'curative training' was one of the most important discoveries within the field of orthopaedics in the war (Wilcock 2002). Thus, the foundations of occupational therapy were firmly established within medicine.

Dr David Henderson, a Scottish physician, spent some time with Adolf Meyer in America and introduced the newly named, occupational therapy on his return to Scotland after the war, appointing Dorothea Robertson as an occupational therapist at Gartnavel Hospital in 1922 (Paterson 2002). Margaret Barr Fulton was born in Manchester but went to America in 1919 and trained as an occupational therapist at the Philadelphia School of Occupational Therapy. On her return to the UK she contacted Dr Henderson who was unable to employ her himself but was able to facilitate her appointment as the first trained occupational therapist in the UK at the Royal Mental Hospital, Aberdeen. Elizabeth Casson trained as a housing estate manager in South London and worked for Octavia Hill, a philanthropist who helped to improve the life of her tenants by establishing playgrounds and green environments for 'ragged school children', and introduced several occupations for the adults, thus encouraging self-reliance. Casson studied medicine and became the first woman to be awarded the degree of Doctor of Medicine of the University of Bristol in 1929. She worked with patients who had psychiatric conditions and was interested in the healing power of creative handiwork. She worked at the Royal Holloway Sanatorium, Virginia Water where there was a tradition of games, entertainment, competitions, sports days and crafts, although not prescribed by medical officers. On her return from America she took steps to establish the first School of Occupational Therapy at Dorset House in Bristol, which opened in 1930 (Wilcock 2002).

The Second World War, like the First, was instrumental in the further development of occupational therapy. The government and armed forces encouraged the demand for increased numbers of occupational therapists to meet wartime needs and training opportunities expanded. The rehabilitation of patients was recognised as important for industry and therefore the economy. With the establishment of the NHS in 1948 occupational therapists negotiated salary scales and conditions of service in preparation for becoming NHS employees. The use of occupational therapy in the physical field of health took primacy over mental health problems. Innovations in medicine and pharmacology, such as the discovery of penicillin meant that more people survived serious illness, such as Tuberculosis and Poliomyelitis but were sometimes left with long term or permanent disability. Although occupation was used to pass the time of someone on long-term bed rest, it also involved analysis of activities, which could be used for a specific therapeutic purpose, in order to enable people to return to work.

Occupational therapy at that time used craftwork as the treatment medium and in addition, problems related to domestic and self-care, were addressed (Wilcock 2002).

Changes to Occupational Therapy Skill

Hagedorn (1995) has plotted the changes to the skill base since the two World Wars. In the 1950s rehabilitation towards return to work was important, as were self-care activities but craftwork was used extensively for its calming or stimulating qualities: commonly referred to as 'diversional' activity. Towards the end of the decade industrial therapy and group work using analytical frames of reference were used in psychiatry whilst in physical health care, long periods of hospitalisation led to programmes of graded therapy based on biomechanical principles. In the 1960s pressure to conform to scientific models drove occupational therapists away from craftwork. Rather than generalised training for self-care, work and play, effort was concentrated on sub-skills of function such as range of movement, hand-eye co-ordination, strength, endurance, self-expression and control (Reilly 1962; Rogers 1982). Tools were developed to measure these things and skills such as splint making were adopted (Yerxa 2000). In psychiatry, group therapy was used, influenced by behavioural psychology. Craftwork was still used but behavioural modification programmes, domestic training, social skills training and industrial therapy were favoured. In the 1970s there was a further decline in craftwork as physical practice became more 'technical'. Reduced admission times meant that there was less time for prolonged graded treatment programmes and attention was focussed on solutions to functional problems of daily living, preparing people for discharge from hospital. In psychiatry, group work took precedence and then with the move towards community care, cognitive therapy came to the fore (Hagedorn 1995).

In the 1980s throughput of patients became more rapid, particularly in acute services, leaving even less time for therapy and the role of some occupational therapists was reduced to 'discharge technician'. The recession made return to work more uncertain and occupational therapy practice was directed more towards helping people to remain independent at home: this was especially important following the Chronically Sick and Disabled Persons Act of 1970. As rehabilitation towards return to work declined in physical hospitals, industrial rehabilitation increased in mental health. This created difficulties with nurses who considered that occupational therapists were encroaching on their area of practice. Following a drive to reduce the number of specialist services and developments within psychiatry such as group therapy and therapeutic communities, a multi-professional approach was adopted and roles were blurred (Wilcock 2002). Mental health occupational therapists then became involved in support mechanisms created to help patients move into the community, such as day centres or 'drop in' centres. Interest developed in applying theory to the therapeutic use of activity or occupation. Language became more academic with an emphasis on 'problem solving' (Hagedorn 1995). The changes that have taken place within health care over the past twenty years; particularly the introduction

of business values with increased speed of patient throughput has the risk of reducing job satisfaction. In response, the notion of occupation as a force for health has now returned as the foundation for occupational therapy practice (Wilcock 2002).

It began in the USA where Reilly (1962) was instrumental in challenging the perception that occupational therapists had to conform so closely to the perception of health held by medicine and she developed the theory of occupational behaviour. Underpinning this theory was the belief that occupation and health are linked and that patients should be involved in the decision-making within his or her life and within occupational therapy. Patients have the potential to master their own environment and improve it and they can be motivated to do so (Reilly 1962; Mayers 2000). Yerxa was inspired by Reilly (Yerxa 2000) and developed the idea that 'occupational science' was relevant to occupational therapy. This theory focuses on the study of humans as occupational beings. Individuals have resources and strengths, which can be tapped through occupation to enable them to adapt to challenges they may face. Yerxa does not advocate a complete split from medicine, suggesting that it is important to understand the natural sciences upon which it is grounded but she argues that it is also necessary to develop an independent knowledge base about 'the occupational human within a physical and social context' (Yerxa 2000). This is receiving some interest in the UK (Mayers 2000).

The so-called client-centred approach has been re-claimed as being central to the philosophy underpinning occupational therapy (Mayers 2000; Sumsion 2000). The Canadian Association of Occupational Therapists produced guidelines for client-centred practice (Department of National Health and Welfare & Canadian Association of Occupational Therapists 1983) and the concept has been absorbed into UK occupational therapy practice (Sumsion 1999). Townsend et al (2003) examined the ways in which the focus on occupations and client-centred practice was complicated by more powerful agencies. The practice of 'working with' rather than 'doing to' changes the unequal power relationship of dependent client/expert professional to one of power sharing. Terms like client enablement and empowerment have been adopted, whilst justice for clients has become an espoused value. However, they argued that occupational therapy is not a powerful profession and the clients they serve also lack power, which renders the notion of enablement difficult to implement. The outcome of their research led them to believe that occupational therapists continue to 'fit in' with the policies and regulations of the institutions for which they work and expect the client to comply with them. They might try to highlight the discrimination that people with serious mental health problems encounter in the work place but it is an up-hill struggle. They were more concerned with raising public awareness of the profession than working with clients to tackle injustices in society (Townsend et al 2003).

The Professional Association

The Scottish Association of Occupational Therapists (SAOT) was founded in 1932, followed by the Association for Occupational Therapists (AOT) for England, Wales and Northern Ireland in 1936. In 1938 the AOT offered the first diploma examination for occupational therapy in England and the professional journal was introduced. The AOT adopted a code of ethics in 1943 (Wilcock 2002). The advent of the National Health Service in 1948 necessitated more formalised structures and in 1952 a Joint Council of Occupational Therapy Associations was set up with equal representation. The intent was to decide on issues such as the code of ethics and to prepare for negotiations towards state registration (Jay et al 1992), which was achieved in 1960. Associations striving to gain recognition adopted conventional status symbols such as a capital city address, armorial bearings and royal patronage. As a consequence, the associations themselves became symbols of how to attain professional status (Millerson 1964b). It is therefore interesting to note that in 1945 AOT set up the first office in London, a single rented room on Brompton Road, South Kensington. In 1989 the headquarters of the professional body moved up-market to Southwark because it was considered more able to 'reflect the current status of occupational therapy' (Jay et al 1992). The badge of the Association, adopted in the 1950s, depicts a central image of the phoenix rising from the flames, with the staff and serpent of Aesculapius underneath. The phoenix was chosen as a symbol of self-regeneration whilst the serpent, curled around the staff, was a symbol of medicine; further reinforcing the medical patronage of the profession. Finally, in 1986 HRH the Princess Royal became the patron of the Association (Wilcock 2002).

In 1974 the AOT and the SAOT merged, after a referendum, to form the British Association of Occupational Therapists (BAOT). This event was described as a milestone to 'further professional endeavour' (Jay et al 1992). In 1978 BAOT formed the College of Occupational Therapists (COT), a registered charity involved in the professional and educational aspects of occupational therapy. BAOT became the nationally recognised trade union for negotiating pay and conditions of service. This disassociation is significant as it suggests a wish to distance the profession from trade union activity and its links with tradesmen and business practice (Millerson 1964b). The values of altruism and service orientation seem to be implicit in this action.

Occupational therapists achieved state registration in 1960 and are now involved in most aspects of health and social care. They can be based in institutions (hospitals, prisons, and schools) or in communities. However, struggle, the threat of encroachment and encroaching on others continues. Barnitt (1990) called for a debate on how aspects of occupational therapy differed from nursing and social work. There have been discussions about whether or not physical and mental health occupational therapists should divide (Rigney 2000). Golledge (1998a) expressed concern that physiotherapists and occupational therapists were

duplicating their skills whilst calls for the combination of the two professions have appeared in the literature occasionally: Smith et al (2000) raising the subject most recently.

In 1989 the College of Occupational Therapists set up an independent body to review the professional state of occupational therapy in the United Kingdom. The Blom-Cooper Report, seemingly influenced by Etzioni's (1969) thinking on semi-professions, described it as a 'submerged' profession. The reasons cited included the dominance of doctors, a damaging public perception, the numbers of women in the profession and the lack of scientific proof of efficacy, which in an environment of restricted resources made occupational therapy a weak competitor compared to more technical medicine. But that was in 1989 and the professional project for occupational therapy has moved on since then.

Comparing the history of occupational therapy to the literature on professions shows that it has broadly followed Wilensky's (1964) historical sequence. A full time occupation emerged first, then a training school in 1930, a professional association in 1932, protection of title should then have been secured (but was not until 1999) and then a code of ethics in 1943. Historical events used by older professions were utilised. The professional association, for example, employed status symbols and a distinction was made between trade union and professional activities. Occupational therapy used the patronage of medicine to become established on the professional ladder and adopted male-defined strategies for gaining power and authority. In line with the professional symbol, which was itself influenced by the functional, trait and power theorists, a discrete area of work was established, along with control of training, control of entrance to the profession, and self regulation supported by a code of ethics and the service ethic. Socialisation ensured a shared identity. Occupational therapists have consolidated their own position whilst excluding those in the lower ranks through state registration.

However, whilst medical patronage had its benefits it also had limitations. Declaring a monopoly of knowledge was hindered because it had to fit within strict boundaries dictated by doctors. Because it was a predominantly female profession and women were denied access to universities for a long time it was difficult to make education scientific and arduous, a prerequisite for status. There is also the idea that the skill is based on feminine 'caring for' rather than masculine 'caring about', which places it in a weak position in society. It has gained a monopoly of work in the NHS but does not have autonomy because doctors have claimed the sole right to diagnose: a key power strategy. Actions such as strengthening the knowledge base and making it independent from that of medicine are aimed at increasing the autonomy of occupational therapists (Townsend et al 2003). It is further facilitated through the creation of consultant therapist posts (Roberts 2001; Craik & McKay 2003). These posts were outlined in the *NHS Plan* (Department of Health 2000a) and have four core functions: expert practice, professional leadership and consultancy, education, training and

CHAPTER 3

METHODOLOGY AND METHODS

This chapter details the methods used in my research. It explains the research design, including the sample, recruitment, ethics, how the quality of data was ensured and the analytical strategy chosen.

METHODOLOGY

The broad differences between the positivist (quantitative) and interpretive (qualitative) approaches to research and related methods can be summarised. The positivist stance uses a normative paradigm based on the idea that human behaviour is governed by rules that are best investigated by the methods of natural science (Cohen & Manion 1994). It seeks to establish universal laws, find causes and aims to predict and then possibly control behaviour. The underlying assumptions are that human beings are similar, that generalisations can be made and that there are common processes or regularities to be studied. The 'taken-for-granted' is accepted and all knowledge can be reduced to observable facts and the relations between them (Little 1991; Cohen & Manion 1994). The methods used may include controlled experiments and tests, which can be objectively replicated by others under identical conditions with standardised procedures. Statistical analysis of results is seen as the analysis of neutral facts and their interrelation. It offers scientific proof or social scientific probability but statistical probability is dependent on the representative nature of the sample in social science if results are to be generalised (Little 1991; Sim & Wright 2000). Critics of this approach argue that the values of the researcher are embedded in experimental designs, the data are subject to 'experimenter effects', may be superficial and create mechanistic or reductionist theories, which may be dehumanising or misleading (Little 1991; Cohen & Manion 1994).

In contrast, researchers who are sceptical about positivism work within an interpretive paradigm, arguing that a single objective reality does not exist because it is relative to the perspective of individuals and the contexts in which they interact (Sim & Wright 2000). Positivism, in their view, ignores individuals' ability to interpret their own experiences. Human behaviour cannot be explained in terms of numbers (Blumer 1969; Hessler 1992). Qualitative researchers aim to understand the subjective world of human experience by examining the viewpoint of the person being studied: investigating from the 'inside' rather than the 'outside' (Sim & Wright 2000). The interpretive paradigm is concerned with the individual and uses non-statistical, subjective models. It looks for interpretations of the specific, and seeks to understand actions and meanings rather than find causes and to investigate, not to assume, the taken-for-granted (Cohen & Manion 1994). Schools of thought used may include phenomenology (human experience and consciousness are the bases of reason and understanding), ethnomethodology (the first-hand study of a human culture) and symbolic interactionism (social life

and the social identity of the individual are created through social interaction), (Sim & Wright 2000). Methods associated with these perspectives are the case-study approach, participant observation or in-depth interviewing (Cohen & Manion 1994).

Mason (2004) advises that it is necessary at an early stage of any research to identify one's ontological perspective; that is, the nature of the social reality to be studied. In my case I see people as an essential property of social reality. I am interested in the social processes in which they are engaged, the interpretations they make, their experiences and understandings. This connects with an epistemological stance that considers people and their interactions to be capable of generating meaning and that this meaning is knowable and worthy of investigation. The position taken was that perceptions about concepts such as professionalism are personal, subjective and possibly unique. Rather than responding in a mechanistic or deterministic manner to the situations encountered in society, human beings have the ability to think and therefore play a creative role in controlling their environment (Cohen & Manion 1994). George Mead (1863-1931) linked the ability of human beings to form perceptions to the development of thought processes, thinking and reasoning ability (Meltzer et al 1975). Perception allows an individual to mediate the relationship between self and the social environment (Meltzer et al 1975). It is through perception that people, in their everyday interactions, sum up whether or not they consider occupations to be professions (Macdonald 1995). These assumptions take into account the fact that people are different from inorganic subject matter. It is therefore, not an appropriate task to define a profession scientifically, as a chapter of pre-defined variables, for example. The approach in this thesis is to ask about the ways in which members of an occupation perceive professionalism and how they aim to achieve professional identity by their activities.

The research strategy chosen followed in the tradition of symbolic interactionism, which is concerned with the nature of interaction between people (Cohen & Manion 1994). The works of James (1842-1910), Dewey (1859-1952), Cooley (1864-1929), and Thomas (1863-1947) informed the genesis of symbolic interaction but its premises can be traced to the works of Mead who taught at the University of Chicago in the 1920s (Meltzer et al 1975). Although he did not publish any books during his lifetime, his renowned writing has been influential, particularly *Mind, Self and Society* (1934) (Meltzer et al 1975). He was concerned with behaviour and the importance of environmental influence but was interested in the ways in which people interpreted those influences. He theorised that individuals acted within a world of meanings that have been generated by the wider context of society but future behaviour was motivated by personal interpretations and perceptions of a social situation (Meltzer et al 1975). Such eminent researchers as Hughes, Blumer, Becker and Goffman developed this perspective (Cohen & Manion 1994). The premises of symbolic interaction are that:

- Human society must be seen in terms of 'what people do'.
- Social interaction is the process that moulds human conduct. The action of others influences an individual's plans and an individual's action has to 'fit in' with the actions of others.
- The worlds in which people live are made up of objects, which can be 'anything that can be pointed to or referred to – a cloud, a book, a religious doctrine etc'. Objects have meaning for individuals but the same object may have a different meaning for different individuals. There is an interpretive element as individuals undergo a process of self-communication, identified by Mead, to transform meanings in the light of particular situations before they decide how to act. It is therefore people, through their interactions who create meanings (Blumer 1969).

The object in this study is professional identity. In Blumer's (1969) terms this meant going directly to that social world and,

To see through meticulous examination of it whether one's premises or root images of it, one's questions and problems posed for it, the data one chooses out of it, the concepts through which one sees and analyzes it, and the interpretations one applies to it are actually borne out (Blumer 1969: p 32)

This was how I intended to study the professional world of occupational therapists. Professional identity is closely associated with one's sense of self. As Moline (1986) reported, we talk of what a plumber *does* but a professional *is* a doctor, a priest, a lawyer for life. If a plumber loses a job he or she can get another one. If a doctor loses a job it is catastrophic. It represents a loss of one's identity: who one is (Moline 1986). The process of becoming professional is grounded in Mead's work on mind, self and society. His formulation of the 'I' (the impulsive, creative self) and the 'me' (the socialised self) provides the basis for exploring the self as a social process. Goffman built on this to provide a rich resource for exploring the social organisation of identity (Atkinson & Housley 2003). Of importance here, is the relationship between the presentation of self, interactions with others and the ritual organisation of social encounters. It involves what the person says, what the person thinks, what the person imagines and what the person 'is' (Atkinson & Housley 2003). Symbolic interactionists have been particularly influential in their research on identity and identity formation. More recently postmodernists and feminists have enhanced the status of qualitative research by concentrating on discovering and contesting processes of identity formation, which is particularly appropriate for professionalism, which may also be seen as a site of contestation (Flick et al 2004). However, some writers regard postmodern descriptions of the concept of identity formation to be remarkably similar to the earlier interactionist work (Atkinson & Housley 2003). Because I was interested in tracing the historical development of the concept in occupational therapy, the classical texts were going to fundamentally inform this

study and therefore it was more appropriate, for reasons of comparative analysis, to adhere more closely to the interactionist tradition.

I wanted to find out why and how professional identity in occupational therapy had developed and how it continues to do so. Because I was looking at a developmental process, the methodological strategy was built around assembling data which could be used to provide an explanation. I could have used an ethnographic approach and examined the cultural and social settings through which professionalism is played. This might have entailed observational and participatory methods of data collection. There are many reasons why this could have been relevant. Observing occupational therapists at work would have facilitated an exploration of daily routines, conversations, actions, and interactions within different settings (Mason 2004). I could have looked for professional behaviour as it occurred and analysed the components. I could have interviewed participants and asked them about their interpretation of events as they happened. As an occupational therapist myself I could have immersed myself in the field and included my knowledge of what it is like to have that experience in the data. This could also have provided a source of tension because it would be necessary to decide how overt or covert any such observation would be. Apart from having to make some difficult ethical decisions, working as a practitioner whilst collecting data would have been too limiting with regard to the range of settings I could examine. I wanted to look at the topic from a range of viewpoints, not just those of practitioners. If I was a non-participant observer, it might have proved difficult to be as open as necessary to what I was observing because at that stage I had a particular perception of professionalism and was probably too close to the situation to give an account which authentically included other standpoints. There was a risk that I would lack reflexivity and be over-selective in the data collection, the result being a naïve analysis. Most importantly though, it was not what occupational therapists were doing that I was interested in but rather what their beliefs, interpretations and perceptions were. It seemed important to understand these dimensions before analysing what they do in practice.

An alternative strategy would have been to use focus groups. They are designed to discover what people think and feel about a specified subject in a permissive, non-threatening environment (Krueger 2000). Participants are chosen for their knowledge or experience of the concept. Using this method would have allowed the collection of data from a large number of participants. The design could have been arranged to include groups of practitioners, educators, regulators and organisers of the profession and cross case analysis could have been undertaken. An ethnographic analysis would have addressed important issues about what was going on between the participants (Silverman 2004). The aim would be to represent occupational therapists' world from their perspective. However, although the purpose is to gather a range of opinions rather than achieving consensus, this method has the capacity to encourage people to influence and be influenced by other group members and I wanted to glean people's individual

accounts without being tempered in this way. I particularly wanted to be able to compare individual views with one another.

Primarily it was people and their perceptions, interpretations, meanings and understandings that were going to be my data sources. This interpretivist approach does not rely on immersion in the setting and lends itself to using interview methods of data collection (Mason 2004). The stance that I have taken is that talking with people, asking questions, listening to them and analysing their use of language is a meaningful way of generating data. It recognises that knowledge about professionalism is contextual, situational and interactional and therefore interviews are likely to be better than questionnaires, for example, at yielding this type of information. An interview schedule can be constructed to draw out the specific experiences of participants; when and under what circumstances something has occurred, what people think or understand about a phenomenon and how they reason or make judgements. This type of information is unlikely to be gleaned from observational techniques. I wanted people to be free to express what they thought was important rather than being restricted to closed, quantitative questions. Qualitative interviewing acknowledges that there is a social interaction between the researcher and participant and that interviewees will hear and interpret questions in an individual way, which in itself will enrich the data. There is an in-built capacity for the interviewer to be part of the process of data collection, something that I saw as important to me as an occupational therapist investigating occupational therapy. Not only would it allow me to correct misunderstandings and to probe as necessary but my own experience could be used in the analysis. It has the potential to reveal the depth, roundedness and complexity of the topic (Cohen & Manion 1994; Mason 2004).

METHODS

The purpose of this study was to investigate the professional world of occupational therapists, what they experience and do, individually and collectively. I found Blumer's (1969) argument for 'inspection' compelling. This procedure consists of examining the subject from all angles and viewpoints, turning it over, asking many different questions and scrutinising the data from the standpoint of the questions. Therefore a decision was made to study occupational therapists working with patients, those responsible for the organisation of the profession, educators and those working for the statutory body. I examined individual practitioner occupational therapists and the joint actions in which, collectively, the College of Occupational Therapists (COT), the universities and the Council for the Professions Supplementary to Medicine (CPSM) were engaged. A programme of in-depth interviews was generated using literature on the symbol of profession and the concept of socialisation to form the framework of questions. The aim was to facilitate an understanding of the defining process, that made individuals and groups make interpretations before undertaking action, within the world of occupational therapy.

The Interview Schedule

In line with the symbolic tradition I wanted to see how respondents were giving meaning to the object of professional identity through the symbolism of language. I was interested in their own accounts: what interpretations and transformations of perception were going on, how they wanted to present themselves in society and how they were attempting to 'fit in' with the actions of others. Questions were generated from the literature on the symbol of profession using the following themes:

- Monopoly of a body of knowledge
- Control of training into professional practice
- Control of entrance to the profession
- Adoption of a code of ethics
- A service ideal
- Socialisation

In-depth interviews have been criticised because the data consists solely of verbal statements which are subject to exaggeration, distortion and there may be a marked difference between what people say they do and what they do in practice. However, the fact that the informant will put on a performance to create an image is in itself a rich source of data. Interviews are an effective method of data collection where the purpose is to examine what a person thinks. They offer the chance to ask and probe extensively to check understanding. Questions can be modified if necessary and a lot of data is produced (Cohen & Manion 1994). Interviewing, though, is a skilful process, requiring tact and understanding, knowing when and how to probe in order that respondents can be encouraged to

clarify and express their thoughts. This requires practice and mistakes are likely in the early stages (Moser & Kalton 1996). It is important to encourage the respondents' own views and to reduce interviewer bias as much as possible (Cohen & Manion 1994; Krueger & Casey 2000; Sim & Wright 2000). There were several sources of bias that needed to be addressed in this case:

Social desirability bias – the tendency for respondents to give an answer expected of them or that would present them in a good light.

Conformity bias – where the respondent anticipates what the interviewer wants to hear or gives an answer in-keeping with the majority view.

Leading questions – where questions are worded in such a way that would imply an answer.

Loaded terminology – where questions contain value-laden words.

One of the ways that bias was minimised was by establishing rapport; trust and putting the respondent at ease (Cohen & Manion 1994). The interviews were collected in an informal setting, within the respondent's place of work. I opted to reveal my identity as an occupational therapist on the basis that I would be regarded as knowledgeable about the topic. However, to establish a balance between 'researcher' and 'occupational therapist' I wore clothes that did not identify my profession. The balance appeared to be a reasonable one as people were relaxed and generally effusive during the interviews. The interview schedule had an easy opening sequence; asking general questions about the individual to put them at ease before moving on to more specific questions. Interviews were conducted one-to-one and I had first hand familiarity with the occupational therapy world. First hand experience is considered necessary to study a world effectively but that too, carries a risk of bias. I was aware that I was entering the study with my own particular interpretations but Blumer (1969) advised that this could be overcome by conscientious and continuous effort to test and revise any images I might have started with. By getting close to the world and scrutinising the data I adjusted my thinking, remained open-minded and expected to expand and deepen my perception and interpretation of it, the intention being to generate fuller and more accurate knowledge. Cohen & Manion (1994) suggest that the motivating drive during the interview process should be for the interviewer to be always curious, to be interested in and to listen to the views of the respondents, which I endeavoured to do. They also proposed other ways to reduce the effect of bias. For example, the questions should be formulated so that the meaning is clear and they should be asked in an acceptable and natural manner.

In this case, an indirect approach was adopted for the questions, as in this example,

I wonder what would happen if people with a criminal conviction – say a benefit fraud, were allowed to train as occupational therapists?

By using this structure I could explore the respondents' perception of trustworthiness or honesty in general and the answers would reveal information about the ways in which it affected their own work situations. By introducing the idea of benefit fraud, rather than a more serious crime, it encouraged reflection away from the extreme, clear-cut cases, where the socially desirable thing to say might be 'It's wrong to have murderers in the profession'. Instead it promoted a deeper exploration of how trust was being perceived. Answers were invited so that the respondents were free to reply as fully as they wanted. This conversational style was more likely to generate honest and open responses. Too much hard or threatening questioning might have resulted in a more calculated response (Cohen & Manion 1994).

The Pilot Study

The aim of the pilot was to test out the structure of the interview schedule. Because the potential pool of educators, COT and CPSM members was small it was decided that a pilot involving these groups was impractical and it was therefore restricted to practitioners. An outline of the project was presented at a staff meeting within my place of work and potential participants were asked to respond to me directly. Six occupational therapists volunteered to participate. The recruits included junior and senior staff who worked in the fields of physical or mental health. One-to-one interviews were conducted over a two week period in a quiet place and at a mutually convenient time. They were tape recorded and later transcribed verbatim. The interview schedule was checked for leading questions, loaded terminology, to test understanding and whether or not the schedule flowed. Relatively few changes were made but the following are examples. This question was changed from,

I'd like to start by talking about OT skills. There's a lot of debate isn't there about what the unique skill of OT is – what do you think?

(Version 1)

To,

I'd like to start by talking about OT skills. Physio's are good at promoting themselves as the only profession skilled at manipulation of the human body. What do you think is the unique skill of OT?

(Version 2)

This was less likely to plant the idea that there is a debate about whether or not the skill is unique. Similarly, this question was changed from,

I wonder if OT skills are difficult to learn?

(Version 1)

To,

OT's deal with basic problems of daily life and sometimes the skills that an OT must have to solve these problems can appear simple. How difficult is it, do you think, to acquire those skills?

(Version 2)

This may be seen as less threatening because it does not point to whether the individual found the skills difficult and allows a wider exploration of the issue. A suggestion was made by some participants that it might be useful to include a question about the degree to which tutors were up to date in clinical skills. This seemed to be important to a number of people so the following question was framed and inserted into the section about 'control of training into professional practice',

When you trained, were your tutors in touch with clinical skills? Is that important do you think?

The final interview schedules are presented in Appendices 1 & 2.

These respondents' co-operation provided helpful guidance on the way that the interviews proper should run. They entered into the study with enthusiasm but because they all knew me it was apparent that this could be a deterrent in answering certain questions, such as what were the more tedious aspects of work. This confirmed my initial decision that I should only interview in areas outside my immediate location. Once the pilot interviews had been completed and analysed it became clear that differences in work setting could have some bearing on perspectives. The theory that was seen to be utilised by the participants, for example, could vary according to whether respondents worked with mental health or physical conditions. Issues such as speed of patient throughput were found to be problematic for some and not others. Different examples of ethical issues were also found in separate areas. Because such factors were highlighted in two settings I concluded that I ought to incorporate all fields of work in my sample group, namely, mental health, physical health and community settings, which was a field omitted from the pilot. Some respondents voiced the opinion that they would have liked to have seen the questions prior to the interview so that they could think about their replies. I gave some thought to this but decided against it. I wanted to capture their spontaneous responses rather than give them the opportunity to present themselves in, what they might have seen as the best possible light and give a measured answer. I concluded that I would glean a more authentic response by not revealing the questions beforehand.

In brief, the main changes were to the wording of the questions to reduce bias and to refine the conversational style as in the examples given. The pilot confirmed that the schedule flowed in a satisfactory manner and it also helped to define the range of work settings to be considered when designing the sample.

Sample

Miles & Huberman (1994) have injected into qualitative research design, what may be considered as more rigorous elements of quantitative analysis, including means of organising the sample group representatively. However, I was more inclined towards the stance of Blumer (1969) who thought that well informed participants are more valuable than a representative sample. The purpose of the study directed who would be invited to participate. The approach was to use theoretical sampling, so that I could identify the groups with knowledge that would be most relevant to the question and its development. I wanted to look at professional identity from four viewpoints. First was that of practitioners who were engaged in, interacting with and interpreting a social world organised for them by others. They could be seen as the enactment or the embodiment of the professional symbol in whatever way that was interpreted. Second was that of the College of Occupational Therapists (COT) who had knowledge about how the profession had been organised in the past, what the ambitions were for the future and the actions that needed to be taken to achieve them. Third was that of educators who hold responsibility for perpetuating the professional symbol but have to mediate between the expectations of the university system, the ambitions of COT and the requirements of government and judicial process. Fourth was that of the Council for the Professions Supplementary to Medicine (CPSM), whose prime concern was regulation of the profession: access to this knowledge could reveal how and why legal structures have been put into place and how this has influenced the professional symbol. These groups were also important because they held different kinds of information about how the professionalisation of occupational therapists had developed to that point. The actions of each group, their opinions and viewpoints, would be the result of a particular stance, influenced and informed by the actions of others in the past and by anticipated future events: this was the data I wanted to target. These then, were the sampling frame from which a well-structured sample could produce the appropriate range of relevant phenomena that could be compared and contrasted between groups to build a well-founded argument (Mason 2004). Interviewing is a time consuming task, not suitable for large-scale surveys but it is advisable for the process of group selection to be considered in relation to the future analysis of the data (Bryman & Burgess 1994). I needed appropriate data to ensure trustworthiness and verification. That required interviews with a sufficient range of different types of practitioners to be sure that the analysis was not reflecting minority or only isolated views and a sufficient range of educators, COT members and CPSM members to facilitate cross-case analysis (Bryman & Burgess 1994).

Practitioner Occupational Therapists

Practitioners are the largest of the four groups in the wider population and in order to gain access to enough data and to cover all angles it was anticipated that this would be the largest sample group. I did not want to produce a representative sample but nevertheless I expected to reflect the typical characteristics that were likely to be found in most groups of practitioners. For practical reasons the

practitioners were targeted from an area within my geographical location. This carried the potential for bias: the findings might be peculiar to that area; I may have known some of the respondents or found it difficult to be open-minded. However, it was the largest health region in England. I targeted every major town in the region to make sure that I covered as wide an area as possible and avoided the town where I worked. Students were excluded because I wanted people who had had some work experience upon which to draw. Recruits were taken from three work settings: community, mental health and physical health. This was intended to draw out the ways in which working in different bureaucratic settings influenced the meanings, interpretations or perspectives taken. Community settings included those managed by the NHS and social services and covered specific fields such as mental health or were all encompassing. I aimed for an equal number of respondents from each work setting and set out to achieve 12 in each. I was not attempting to establish causality through the data but rather to compare experiences. Because the range of experiences was unknown at the outset of the study but likely to be complex I wanted to ensure that I had sufficient numbers in each group to explore them fully. If there was some factor pertinent to community occupational therapists to be found I wanted to be able to find it. Similarly, if all groups felt the same way about something I wanted to have enough data to be confident about making that statement. In the event, 12 volunteered from community, 11 from mental health and 13 from physical health: 36 in total, which is large for a qualitative study but necessarily so for adequate variation of data.

Most texts about sampling procedures advise that it is necessary to build a sample of sufficient range of variation to understand the process of, in this case, professionalisation, and that it should be a dynamic and flexible practice (Mason 2004). I was prepared to adjust the boundaries of the target sample if necessary but by the end of the interviews, no new data were revealed and therefore saturation point was reached, indicating that the sample was adequate. There were 19 graduates and 17 diplomates, which would allow an exploration of whether or not education had any bearing on peoples' views. There were nine practitioners, within each grade of seniority: basic grade, senior 2, senior 1 and head, which would be helpful in understanding how professional identity developed over time. Ages ranged from 22 to 63 and there were five males and 31 females. The size of work setting ranged from a 14-bedded unit to a large teaching hospital with 1296 beds. This spread promised to offer a wide range of experiences and made it easier to look for similarities or differences between groups, which would help to understand what was going on. This sample group is a cross-section and illustrative of occupational therapists likely to be encountered anywhere in the UK, which therefore reduces the potential for bias inherent in limiting the geographical location. The anonymised data are listed in Table 1. Only the barest information is given about area of work and type of work setting to protect anonymity.

Table 1: Profile of Practitioner Occupational Therapists

OCCUPATIONAL THERAPIST	GRADE	AREA OF WORK	TYPE OF UNIT	QUALIFICATION
1	Senior 2	Physical	Hospital	degree
2	Head	Community	Health centre	diploma
3	Basic grade	Community	Health centre	degree
4	Senior 2	Physical	Hospital	degree
5	Head	Physical	Hospital	diploma
6	Head	mental health	Hospital	diploma
7	Senior 2	mental health	Hospital	diploma
8	Head	Physical	Hospital	diploma
9	Basic grade	Physical	Hospital	degree
10	Senior 1	Community	Health centre	degree
11	Senior 1	mental health	Hospital	diploma
12	Basic grade	mental health	Day Hospital	degree
13	Basic grade	Community	Hospital	degree
14	Head	Physical	Hospital	diploma
15	Senior 1	Physical	Hospital	degree
16	Basic grade	mental health	Day hospital	degree
17	Senior 2	Community	Social services unit	degree
18	Senior 2	mental health	Mental health centre	degree
19	Head	Physical	Hospital	diploma
20	Senior 1	Physical	Hospital	diploma
21	Senior 2	Community	Hospital	degree
22	Basic grade	Physical	Hospital	degree
23	Senior 2	Physical	Hospital	degree
24	Head	Community	Health centre	degree
25	Basic grade	Community	Health centre	degree
26	Head	mental health	Mental health unit	diploma
27	Senior 1	mental health	Mental health unit	diploma
28	Head	Community	Social services unit	diploma
29	Basic grade	Physical	Hospital	degree
30	Senior 2	mental health	Mental health unit	degree
31	Senior 1	Community	Social services unit	diploma
32	Senior 1	Community	Social services unit	diploma
33	Senior 2	Community	Social services unit	diploma
34	Basic grade	Mental health	Hospital	degree
35	Senior 1	Mental health	Mental health centre	diploma
36	Senior 1	Physical	Hospital	diploma

The College of Occupational Therapists

The strategy was to invite participants from a range of contexts in order to make cross-case comparisons and to increase the chance of being able to use all of the detail to understand perceptions from all angles (Mason 2004). Although there was some effort made to make the cohort of practitioners illustrative of most occupational therapists, purposive sampling was undertaken for participants from the other groups. They were approached because they were a member of COT, an educator or a member of CPSM and were judged to have information that typified their position (Cohen & Manion 1994).

I wanted to glean the experiences of people who had the task of organising and developing the profession; to discover what they thought was important for progress; what the limitations were, how they viewed the actions of their predecessors and what their plans were for future action, through an exploration of the professional symbol. It was therefore necessary to target people in senior positions, who had responsibility for strategic planning. The pool of potential participants was small. Key members of the professional body were invited to participate and seven volunteered. These seven covered a broad spectrum of responsibility, which I considered acceptable.

Educators

Two universities, offering an occupational therapy programme and located in the same health region as the practitioners, were approached. Four educators volunteered (two from each). This was a poor response but efforts to try to improve it, such as follow-up letters, telephone calls or opportunistic conversations, were fruitless. The reasons for this response rate remain unknown but the impression was that educators were weighed down with work and lacked interest in the topic. One educator declined to participate, declaring that professionalisation was not an important issue for occupational therapists. In many ways it would have been enriching to have been able to examine this viewpoint but to no avail. I could have extended the search to all universities within the UK but I considered that this would make the sample too large. I therefore made the decision to restrict it to the four who volunteered and accept that this particular aspect may not provide the whole picture. It remains useful, however, to include their data to give a flavour of how some educators think and I am especially grateful for their time.

Council for the Professions Supplementary to Medicine

I took the view that members of the regulatory body would be non-partisan towards occupational therapy. Their opinion would be formed by law, government policy and safety of the public and I considered it important to capture this perspective. The potential pool of respondents who had enough knowledge about the topic was small (nine) and three volunteered. Those three

had a lot of cumulative information to offer and so despite the smallness of the number it can be regarded as satisfactory.

Ethics

Theorists offer a number of basic principles to be considered when deciding whether or not an action is 'right'. Four common principles are:

Beneficence - doing good

Non-maleficence - not causing harm

Justice – treating people fairly

Autonomy – respecting the right to self-determination (Miles & Huberman 1994).

Taking these into consideration the following ethical rules were employed to develop trust between researcher and participants (based on Miles & Huberman 1994; Cohen & Manion 1994):

Veracity – potential participants were given accurate information about the study so that they were not misled.

Privacy – participants should have control over the researcher's access to themselves and their information. In this case, respondents had the right to decline to answer certain questions, for example, although no one did so.

Confidentiality – participants should know what will be done with the data. The raw information, including audiotapes was kept securely and accessed only by myself or supervisor. The researcher should not disclose information learned to others without the participant's permission. Participants were made aware that direct quotes may be used in the reporting of the research. However, if a respondent had disclosed unsafe practice this would have necessitated a decision about whether or not to breach confidentiality. No such occasion arose.

Autonomy – information provided by participants should not reveal their identity. All participants have been given a code in the text and the names of hospitals or towns or any other identifying material has been deleted. This further enhances privacy.

Among the other ethical issues considered was whether or not the project was worth doing. It was of personal interest but what of others? Most of the respondents reported that they were pleased that professional identity of occupational therapists was being addressed in this way and that it was 'about time'. They willingly gave up their time and appreciated being listened to; the study gave them a 'voice'. Some expressed an initial concern that they would say something that put them in 'a bad light'. Such concerns were dispelled as the interviews progressed. There were no comments that were ethically contentious and there was no risk of harm to self-esteem or reputation.

Routes of Access

In the first instance access was negotiated through a gatekeeper: an appropriate manager in each work unit or a senior person in an institution. I requested and was given a list of practitioners. I was dealing with hospitals, organisations or institutions where information is freely available to the public: 'visible' settings according to Sim & Wright (2000). The gatekeeper was provided with information affirming that ethical principles would be followed and a formal letter of request was posted (Appendix 3). The use of gatekeepers ensured that the manager was giving permission for staff to spend time with the researcher (Cohen & Manion 1994). The manager in most cases highlighted people who had expressed an interest in participating, although they did not choose who I should interview. This voluntariness reduced the risk of coercion from the researcher. I also recruited some people by approaching them directly. This voluntary nature of the sample might have had some impact on the interviews. The fact that people put themselves forward suggests that they might have an interest and would have formed opinions about the subject matter, which could be a source of bias. However, I wanted to explore the ways in which the respondents had created interpretations within their world of objects and the fact that they might have given some thought to this was considered an asset.

Informed Consent

For an individual to give informed consent a number of conditions need to be satisfied. Consent is necessary to allow the participant to exercise self-determination. Cohen & Manion (1994) and Sim & Wright (2000) have outlined the following components:

Information – given to potential participants should include anything that could influence the decision to participate. Verbal information following guidelines suggested by Cohen & Manion (1994) was provided for all potential participants (Appendix 4).

Understanding – The participants had a shared understanding and comprehension of what was involved.

Voluntariness – Consent was given without coercion or manipulation.

Competence of potential participants – All of the participants were competent to agree.

Actual consent to participate – Verbal consent was confirmed by formal letter (Appendix 5).

Quality of Data

Cresswell (1998) and (Krueger & Casey 2000) have looked at the arguments for and against applying quantitative structures to qualitative methods and their recommendations have been followed, which were:

- To use the term 'verification' instead of 'validity'. Another researcher should be able to arrive at similar conclusions using the same data. For analysis to be verifiable there must be enough data to form a trail of evidence.
- Verification should be considered a strength of qualitative research, guaranteed through extensive time spent in the field, detailed, thick description and closeness to participants in the study.
- To employ the Lincoln & Guba (1985) terms of trustworthiness and authenticity as concepts in establishing the quality of data. Four criteria were suggested:

Credibility (rather than internal validity). This was ensured by lengthy engagement in the study, gaining rapport and trust to test for misinformation and to reduce the effect of 'performance' by the participants.

Transferability (rather than external validity or generalisation). When an individual wants to use the results he/she should judge whether the findings could transfer to another situation.

Dependability (rather than reliability) was ensured by explaining how the study was done.

Confirmability (rather than objectivity) was ensured by grounding the findings in the data and providing quotes as illustration, addressing researcher bias and revisiting the literature.

Analytical Strategy

The purpose of the study drove the analysis. I wanted to see the professional world as the respondents saw it. From their descriptive accounts I wanted to see how they acted towards things. Interviews were conducted at a mutually convenient time and place. They were tape-recorded and lasted for between one and two hours. Towards the end of each interview the data was summarised for the interviewees to verify that I had understood their viewpoints correctly. They were transcribed verbatim and non-verbal communication was noted. Transcriptions were undertaken as soon after the interview as possible and placed in electronic files chronologically. Hard copies were printed off and stored in a secure place. I conducted interviews firstly with COT members, CPSM members and then practitioners and educators simultaneously. Transcriptions were stored under these group headings.

I first started to analyse the practitioners' transcripts. The theoretical concept of the symbol of profession dictated the overarching themes:

Monopoly of a body of knowledge
 Control of training into professional practice
 Control of entrance to the profession
 Code of ethics
 A service ideal

Socialisation

Taking each theme in turn, transcriptions were inspected for units of general meaning as they were read. To a large extent the categories had been predetermined by the questions I had asked; uniqueness of skill, theory, tying practice to science, and so on. I had these in mind as the transcriptions were read and I tagged, with codes, parts of the text that appeared to be saying something pertinent to a category. Sim & Wright (2000) suggest that interpretations of data should be imaginative without being fanciful. One way of keeping a balance is to return often to the actual words of the respondents and to use what they call 'low-inference descriptors' when initially analysing the data. In this case the codes were simple and emerged from the data rather than being pre-set; CS = the skill was common sense, APT = the skill requires aptitude, for example. Each transcript was read in turn. I checked that the codes were applicable to each one and created new ones as necessary. As the procedure continued, the plausibility was checked against the literature to test their verification and I repeatedly went back to the conceptual framework of the professional symbol, looking for links. For example, comments about high entry requirements and whether or not higher education attracted the wrong sort of person into the profession were coded and formed into the category 'university education' which fitted the theme 'Control of training into professional practice'. The codes and categorisation were tested and revised, as the data were re-read. For example, after initially creating a code about vocation it became clear that people were really talking about the intrinsic value of their work and the code was changed accordingly. Coded comments about the British Journal of Occupational Therapy were scattered throughout the discourse and these were eventually absorbed into a category about mystification. Details of the ways in which codes and categories emerged are presented in Appendices 6-11.

Once I had completed this initial reading of all of the transcripts for practitioners I generated new files composed of all the coded material within each category and theme. So I had a file for the theme 'monopoly of knowledge', which contained data from all of the transcripts about the following categories: unique skill of OT, difficulty of skill acquisition, theory, tying practice to science, mystification, distance and power of COT. The data from the community, mental health and physical health groups were analysed separately to facilitate scrutiny of differences between them and then analysed again as a composite group. This work was read and re-read and then compared with the literature on the themes. The data from COT, educators and CPSM members were handled, using the same principles. That data was then cross-analysed with all of the other groups of data. The result was six thematic files containing data from all groups. This meant that I could systematically view the data in sections, retrieve them easily, and move it as necessary to make order and compare and contrast across groups. This helped to organise the conceptual and analytical thinking. This constant comparison across groups was used to enhance verification of the data by demonstrating several dimensions of the concept. In accordance with Mason's (2004)

understanding of the terms there were times when I read the data literally, interpretively and reflexively. So, for example, sometimes I was interested in the literal form of what had been said; how often had people used adjectives such as 'status', 'credibility', or 'expert' to describe something. At other times I was concerned with the way in which interviewees were interpreting something; such as the impact of mystification on others' perspective of occupational therapy practice. There were occasions when I made my own interpretations; how the reluctance of practitioners' to work in low status areas could contribute to the stigmatisation of certain groups of people, for example. There were also instances where I made a reflexive reading of the data. Most notably the work on transformations in self-conception as professional identity developed included my own experiences within the data generation. I was prepared for the analysis to reveal information at a deeper level than was, at the time of data collection, known to the respondent or myself. I anticipated taking new directions, looking at what was actually happening rather than what I supposed was happening (Blumer 1969). Whilst the interpretations are mine they are rooted in the direct experiences of the respondents. Scrutiny by another researcher tested the credibility of the analysis.

The quality of the analysis depends on how thoroughly the interpretations can be warranted. This depends on how well they account for the detail in material and how plausible the account seems (Bryman & Burgess 1994). I set out to present an argument about how professional identity has developed over time for occupational therapists and how the process operates in the present. I have built the argument by highlighting a range of perspectives, experiences and viewpoints, including my own. The theoretical underpinnings of the professional symbol have been tested against the data but in common with most qualitative researchers' view of the social world it is a view of the 'real world' as I have interpreted it (Mason 2004). For reasons of verification I have tried to demonstrate how that interpretation was reached by explaining how the argument was constructed. In order to display the argument in a clear way the following format has been used. The results chapters are set out with a retrospective review of the literature first, leading to the questions that participants were asked so that they are fresh in the mind of the reader. The analysed data for each group is then presented, with a summary at each appropriate point, culminating in a discussion in which the viewpoints of all groups are compared and contrasted. The points are illustrated with quotes. I was interested in the symbolism of the language used in the narrative and also in the details: pauses, 'erms', gestures, voice features, the way that people 'thought out loud' in incomplete sentences until they produced coherence. Some argue that such detail in content and linguistic form is there for a purpose and can add to the analysis (Bryman & Burgess 1994; Sim & Wright 2000). These details have been retained in the quotes so that the context in which they were said is apparent and to provide additional information. When a comment was accompanied by a gesture or said with emphasis it revealed intentions such as gaining pride or appearing authoritative or showed how something was being regarded; with derision or humour and so on. The quotes

are therefore presented as they were actually said. In this way the risk of introducing bias through paraphrasing or summarising is reduced and the accountability of the points made is enhanced.

The choice about which quotes to use was based on a number of issues. Their purpose was to provide evidence in support of a point being made and I tried to ensure that a range of voices were represented, not just the most articulate. I wanted to give some idea of how the quotes I chose were related to those left out. I could have, and did, express this qualitatively (this quote is typical or common, for example) but I also wanted to present them in numerical terms to demonstrate the accuracy of the argument. Percentages were used as a form of standardisation and for ease of comparison across the groups. It was a starting point and they were not being used as the only analytical description of the interpretations being made. Where the quantification was deemed to be important it has been indicated in the text. There are occasions where only 11% of people noted something particular. This equates to four people and could have been the result of probing in one or two specific interviews. It may have been something that others had not thought of but may have had an opinion about, if they had been asked. This may not have been an ideal use of percentages and it might have been preferable to say '4 out of 36 people said this' but I decided to retain the percentages to demonstrate how commonly something was expressed; reflecting the frequency of people reporting a similar thing. I was testing for strength of opinion, which allowed comparisons to be made across and between groups. I considered it to be more informative than simply to say 'many' or a 'few'. Sim & Wright (2000) note that allocating frequency to a category does not necessarily indicate its importance to the respondent or analyst and they should be read with this frame of mind. Others argue that simple descriptive counts of codes are an effective way of providing a summary of the data as a whole (Silverman 2004). Miles & Huberman (1994) argue that counting in this way is important for verification and to keep oneself analytically honest, protecting against bias but it is 'practical' rather than 'statistical' data and I certainly was not trying to impose inferential statistical tests. The reader is free to judge whether or not he/she agrees with the interpretations.

CHAPTER 4 - FINDINGS

The next six chapters outline the findings from the analysis. A retrospective review of the literature is given first, leading to the questions that participants were asked so that they are fresh in the mind of the reader. The analysed data for each group (practitioners, COT members, educators and CPSM members) are then presented, with a summary at each appropriate point, culminating in a discussion in which the viewpoints of all groups are compared and contrasted. The analytical points are illustrated with direct quotes. Data showing the initial coding and categories for monopoly of knowledge are presented in Appendix 6.

MONOPOLY OF KNOWLEDGE

Becker's (1977) first characteristic composing the symbol of a profession was the adoption of a unique skill. A profession must find something to monopolise as its own. The knowledge associated with that skill must have a particular composition. It must be intellectual and complex (Freidson 1984). The knowledge must not be applied routinely, otherwise anyone could learn it, but should require judgement and interpretation (Becker 1977). It should be difficult to learn (Larson 1977). It must not only be a technical skill, requiring practical experience but also esoteric, using abstract principles arrived at by scientific research and logical analysis (Becker 1977). Macdonald (1995) analysed the work of Abbott (1988) who placed great importance on abstraction. He made the point that professional knowledge should be placed midway along a continuum, which has abstraction and concreteness at either end. Too much abstraction would be regarded as formalism whilst too much concreteness judged to be no more than a craft. Some religious practices have been criticised for excessive observance of form and at the other end of the scale the use of domestic activities in occupational therapy has been regarded as too basic to warrant professional status (Creek 1996).

Professions, when making changes to their skill and knowledge base, have kept these components in mind. For example, advancements within health care services have led to certain aspects of the work to be downgraded. Doctors have delegated some tasks to nurses who, in turn, have passed other tasks to auxiliaries. The type of activity to be discarded is usually the less interesting, unclean or unpleasant task, described as 'dirty work' by Hughes (1981) and it is part of the process of occupational mobility. New workers come in at the bottom of the ladder to take over the tasks abandoned by those climbing it. Freidson (1994) viewed this as a positive side of professionalism because it produces new knowledge, skills and ideas. Goode (1969) thought that the professions should help to create, organise and transmit knowledge. There should be change in the knowledge base to maintain exclusivity of expertise but Larson (1977) cautioned that it should be perceived as progress and not deliberately manufactured pseudo-expertise.

THE UNIQUE SKILL OF OCCUPATIONAL THERAPY

The possession of a unique area of expertise belonging to occupational therapy is problematic from a number of accounts. Firstly, the skill on which the professional claim has been based is the use of activity, which has become synonymous with crafts (Holder 2001). This would place occupational therapy too far across the concrete end of Abbott's continuum. Secondly, there has been widespread recognition that there is overlap with other professions such as physiotherapy, nursing and social worker (Stewart 1994). Thirdly, it is difficult to claim that an esoteric body of knowledge is required. Although the intrinsic therapeutic value of activity has been recognised, the ordinariness of the skills involved in occupational therapy is evident. As Jenkins & Brotherton reported,

Practice does not revolve around abstract principles but on real life situations. (Jenkins & Brotherton 1995a: p 332)

Occupational therapists aim to make small but significant improvements in the lives of patients but using everyday activities as treatment media makes their work look deceptively simple (Creek 1996; 1997). Much of the work has been seen as common sense, practical and having little formal credibility (Jenkins & Brotherton 1995b; Mocellin 1996). It therefore would not meet Flexner's (1915) criteria, having dismissed banking as a profession for similar reasons.

Occupational therapy is an example of a profession taking up work that was abandoned by others. Early in the twentieth century craftwork was used for diversional purposes, to occupy the time of someone on long-term bed rest but it also involved analysis of activities, which could be used for a specific therapeutic purpose, in order to enable people to return to work. Neither doctors nor nurses were able to offer this service so the work was passed down to occupational therapists (Blom-Cooper 1989). As occupational therapists tried to move up the ladder, more 'technical' media were introduced, ostensibly in response to medical advancements but also because a stereotypical image had developed which stemmed from their early roots as 'do-gooding volunteers' (Blom-Cooper 1989). For example, Dr Sterling Bunnell had concluded during the Second World War that hands were difficult to treat because of their tendency to stiffen and he designed splints to 'coax joints around from the position of non-function into that of function' (Bunnell 1946). As hand surgery developed the need for splints grew and eventually occupational therapists took over the role of making them (Colditz 1983). Innovations in thermoplastic materials made their design ever more sophisticated.

Some occupational therapists considered that the association with crafts stigmatised the professional image and there was some distancing from it (Williams et al 1987). However, having dispensed with craftwork as the unique skill, something had to be found to take its place. In response, the term 'activity' was introduced, which has now been replaced with 'occupation' in an attempt to underpin the work with an academic foundation (Nelson 1988; Ilott 1995;

Mountain 1998). This has generated debate about the linguistic merits of 'occupation', occupational performance skills, functional occupational performance, and 'purposeful activity' and 'activity', with questions being asked about the purpose it is serving (Hagedorn 1995; Golledge 1998b; Ryan 2001).

This rejection of craftwork could be seen as an attempt to get rid of 'dirty work'. Having accepted it from doctors it was then discarded as occupational therapists strove for upward mobility. It was not literally dirty but perceived as inhibiting any improvement in status. Throughout the decades there have been many alterations to the work of an occupational therapist. Those working in physical health moved onto assessment of range of movement and muscle strength using more sophisticated equipment or the provision of equipment to facilitate safe discharge. In mental health, group therapy was used, influenced by behavioural psychology and then occupational therapists became involved in support mechanisms to help patients move into the community (Hagedorn 1995). From the 1990s to the present, the focus has been towards enablement and person-centred practice with an emphasis on self-health, reinforced by scientific evidence (Wilcock 2002).

In order to understand practitioners' perceptions of the skill of occupational therapy, its knowledge base and the effect of changes, the following questions were used:

- I'd like to start by talking about OT skills. Physiotherapists are good at promoting themselves as the only profession skilled at manipulation of the human body. What do you think is the unique skill of occupational therapy?
- OT's deal with basic problems of daily life and sometimes the skills that an OT must have to solve these problems, can *appear* simple. How difficult is it, do you think, to acquire those skills?
- In your day to day work do you still use much of the theory that you were taught during your training?
- There may be some tension between OT's who think that their work should be more scientific and theory based and those who think that they need to be more practical. Where do you stand on this? Why is that?
- Occupational therapy language has become more scientific over the years. There are phrases like 'cognitive and psychosocial components' and 'models of practice'. Is this necessary or helpful do you think?
- I'd now like to introduce the idea that, although there is concern about building rapport with patients, you are advised not to get too close. To put things on a formal footing, some OT's would rather patients call them by their

title - Mrs./Ms/Mr. so and so. But others opt for their Christian names to be used. Do you have any preference? Why is that?

- Many occupational therapists wear a uniform and people might use facilities like staff rooms and separate toilets, which help to create a distance between therapist and patient. Do you think these things are important? Why is that?
- As you know the professional body is the COT. How much authority or power do you think COT has in deciding what the work of an OT should be?

THE VIEWPOINT OF PRACTITIONER OCCUPATIONAL THERAPISTS

Professional Skill

There is a widespread perception that occupational therapists have difficulty identifying a skill that is unique to their profession. Chevalier (1997) commented that they were constantly searching for meaning in their work in a never-ending process of trying to define themselves and the nature of what they did. These conflicts have been reflected in an abundance of definitions. There are separate definitions developed by the College of Occupational Therapists (COT), the Committee of Occupational Therapists for the European Communities (COTEC) and the World Federation of Occupational Therapists (WFOT). It would appear that clarity, is some way off and that occupational therapists still have difficulty in describing what they do (Mountain 1998; Holder 2001). Over the years the definitions have been altered, lengthened and 'jargonised' to use Wilcock's (2002) term. In 1989 Blom-Cooper criticised the available definitions for being too broad and unfocussed and made recommendations for a simpler one. The College of Occupational Therapists' (COT) 1994 definition stated that,

Occupational therapy is the treatment of people with physical and psychiatric illness or disability through specific selected occupation for the purpose of enabling individuals to reach their maximum level of function and independence in all aspects of life. The occupational therapist assesses the physical, psychological and social functions of the individual, identifies areas of dysfunction and involves the individual in a structured programme of activity to overcome disability. The activities selected will relate to the consumer's personal, social, cultural and economic needs and will reflect the environmental factors, which govern his/her life (College of Occupational Therapists 1994).

In this study, practitioners were consistent in their perception that the unique skill of occupational therapy was the analysis of day to day functional problems with the aim of improving independence. This quote was typical.

OT8 (physical): I think the OT's core skill... is really functional activity and activity analysis. Linking into that er I suppose the easiest way to look at it is how somebody deals with their daily living skills. So whether

that's from physical disabilities or cognitive disabilities or other mental health and learning disability problems, so it's very much on a functional level.

The COT definition would be acceptable to these respondents although they might take issue with the phrase '*maximum* level of function and independence' because it assumes that this is an aspiration universal to all patients. However, their perceptions also match a new definition commissioned by COT and produced by *Jennifer Creek. Although it is described as the first single definition of occupational therapy in the UK, it is in fact a descriptive account of what occupational therapists do as an aid to research, part of which is summarised below.

Occupational therapy focuses on the nature, balance, pattern and context of occupations and activities in the lives of individuals, family groups and communities. It is concerned with the meaning and purpose that people place on occupations and activities and with the impact of illness, disability or social or economic deprivation on their ability to carry them out. The main aim of occupational therapy is to maintain, restore or create a match, beneficial to the individual, between the abilities of the person, the demand of his/her occupations in the areas of self care, productivity and leisure, and the demands of the environment. Occupational therapy personnel work with people of all ages, with physical, mental and social impairments and learning disabilities. They work with people who have multiple and complex problems, people with minor coping difficulties and those who are functioning well and wish to maintain and promote their wellbeing (Creek 2003).

There has been a subtle change though, in the use of the word 'occupation'. As the 1994 COT version had done, practitioners used the noun 'function' rather than 'occupation' to name what was being defined; the overarching 'thing' that is to be improved. For example,

OT19 (physical): I think it's our ability to look at function and analyse what... what people need to do and then be able to er... transpose that into activities or treatments that will replicate that and increase the patient's independence.

*Jennifer Creek is an occupational therapist who has had a varied career encompassing clinical work, education and research. She has written extensively on theory and practice in mental health. She is the editor of an undergraduate textbook *Occupational Therapy and Mental Health*, and has edited a collection of essays on occupational therapy philosophy and theory, *Occupational Therapy: New Perspectives*. She is on the editorial board of the Association of Occupational Therapists in Mental Health journal. She presently works freelance, doing mental health promotion projects, consultation, teaching and writing. She was commissioned to write a definition of occupational therapy as a complex intervention by the College of Occupational Therapists in partnership with the South London and Maudsley NHS Trust (BAOT/COT 2005).

In the College of Occupational Therapists' (1994) definition 'occupation' was synonymous with 'activity'. The practitioners in this study preferred the term 'activity' to describe the instrument through which function is improved, as this quote shows.

OT26 (mental health): Certainly the use of activity, the use of purposeful activity to... improve function or to erm... to improve existing function but also to teach people new function.

Creek's (2003) replacement of 'function' with 'occupation' reflects the attempt to inject an academic element into the professional skill. It marks the change from the use of activity as therapy to focussing on the occupations of the individual. She went on to describe how occupational therapists begin the process of intervention by looking at deficits within a patient's range of occupations (functions). The focus is then on the activities, tasks or skills that will remedy the problem and that was precisely how 53% of practitioners described occupational therapy. This respondent for example, recalled something that the principal of a university said about the unique skill, at an early stage of the education process.

OT10 (community): What she then said, was it was about our ability to carry out assessments and to use activity as therapeutic tools. And she drilled us into that to the point where I came out really proud knowing that I was **special** because I could do that better than **any** other discipline...

Alternatively occupational therapists will make environmental modifications or look at behavioural adaptation to facilitate occupational performance (Creek 2003). In this, 47% of practitioners were agreed. In these characteristic quotes, adaptation through the analysis of environmental factors or behaviour was highlighted.

OT21 (community): It's about enabling people, it's about... you know, they've come to some sort of crisis point in their life and they think 'how am I going to get back to what I used to do?' And if they can't get back to what they used to do then at least I can come up with ideas... of what they might replace that with or... how they can get back to doing things. So I see myself... as someone who's an enabler really erm... I don't ever think we have any miracle cures or anything... but if we can't find solutions then I think we try and find ways round it... something... alternative to do.

OT7 (mental health) I think it's mainly... skills of other people that you're able to evaluate and assess and make an appropriate assessment about where they need to go particularly in mental health it's the... perhaps looking at peoples' ability to cope and... functioning sort of coping skills, problem solving.

Although they used different terminology there seems to be agreement between Creek (and therefore the COT) and the practitioners, that function (occupation) is the key area of professional skill and there is a degree of choice about the methods employed to remedy problems i.e. activity or environmental/behavioural modification. It suggests that the debate about defining occupational therapy concerns academics more than it does practitioners. Having found it fairly easy to define occupational therapy how difficult did they think the skill was to acquire?

Skill Acquisition

Only 28% of the group considered that the skill was difficult to learn. This view was expressed in the following quote.

OT4 (physical): I think it is quite difficult to get to grips with and to think about everything when you're talking to a patient...To take everything into account, it is quite difficult really. It's a skill and it's got... I think it takes a while to learn... and even then there's still things that er... you've missed.

Most though, as in this example, thought that the skill was straightforward.

OT35 (mental health): No, I don't say it's a complicated thing to acquire, I think there's a fair amount of application to... to appreciate why... what's being done is being done but I don't say it's difficult to acquire.

Thirty three percent thought that the skill was a matter of common sense, a point made in this extract.

OT16 (mental health) You need to have an awful lot of commonsense, which is a quality that most OT's have... You've got to break it down... the task... is where an OT comes in... they'll know exactly what to look for.

This quote reflects the 31% who thought that aptitude was necessary.

OT19: (physical) I think you have to be the right sort of person to be able to learn those skills and to be able to use them effectively.

Twenty two percent thought that the skill could be acquired with practice, as this practitioner reported.

OT5 (physical): I think you're learning through experience of people and working... I'm sure you do... I couldn't say that I've learnt it from a book.

Eleven percent confessed to occasions when they thought that anyone could do the job, a view that this practitioner expressed. The point being made was that, whatever additional skills had been taught, what were needed in the workplace were straightforward, technical skills.

OT21 (community): Sometimes you think, well anybody could do this... I think you forget the skills you do have... The assistants are great, my assistant is great and really sometimes I really think well what's the difference between us...? I've got responsibility: *she* does...

The data indicates that occupational therapy skills are not particularly difficult to learn. The more essential requirements include common sense, practice and having the right aptitude. Also included were good interpersonal skills, the academic version of 'getting on with people' according to Eraut (1985). The majority of the group therefore refuted the idea that the skill of an occupational therapist was arduous to acquire.

Linking Professional Knowledge to Science

Society has a belief in scientific knowledge as a symbol of expertise, an idea that developed in the nineteenth century and was confirmed by technological progress (Schon 1991). Larson (1977) observed that scientific communities assume all remaining problems can be solved by using uniform and standardised practices and because scientists are the only producers of science the public has no choice but to accept their definitions of scientific practice. Professionals are in a less secure position, being expected to solve practical problems, and they survive by gaining the trust of their clients in believing that only they are equipped with the expertise to do this. According to Larson, the greater the link with science the more advantageous it is for professions, in a free market, to convince the public of their superior skill. Thus, professions strive for scientifically based education, which may not have much bearing on practice, in her opinion, but gives the impression of competence. Macdonald (1995) made a similar point in exploring professional knowledge, arguing that although professions tackle human problems that benefit from expert service, at the same time,

The academic, formal, abstract knowledge system must not only exist but be actively advanced, since it provides both legitimation and the scientific development that is necessary to maintain the professional jurisdiction of practice (Macdonald 1995: p 164).

Various attempts have been made to offer a unifying theoretical base, which would align occupational therapy to science. Blom-Cooper (1989) noted that occupational therapy suffered from indecision regarding its core philosophy. In its early stages there was a reliance on patronage from the medical profession to give it a 'scientific edge'. It has used theoretical and practical constructs from several disciplines but research has emerged only in the last twenty years (Ryan 2001). Occupational therapists are not alone in their endeavour to tie practice to

science. The same debate has been ongoing within nursing and complementary therapies for many years (Davies 1996; Cant & Sharma 1996). Within occupational therapy, from the 1980s the language of academia was adopted to a greater extent and efforts were made to create a more scientific and objective image (Taylor 1995).

Keilhofner (1992) was one of several theorists who argued that a scientific paradigm should be applied to occupational therapy. The discipline of occupational science has also been put forward to guide the development of occupational therapy as an academic discipline (Reed & Sanderson 1999). It has evolved from the work of Yerxa et al (1989) and Clark et al (1991), in the USA investigating the complex nature of engagement in occupations and its use in therapy. The aim is to distinguish it as scientific inquiry about the phenomenon of occupation, rather than the application of knowledge to particular problems (Reed & Sanderson 1999). Rather than using knowledge based in the traditional medical sciences, other academic disciplines, such as human geography, sociology and anthropology were seen as having potential to add to the knowledge of occupation (Illott & Mounter 2000). These are not scientific disciplines, yet proponents believe that,

Quantitative multivariate-causal modeling analyses may be appropriate for a wide spectrum of research problems in occupational science (Clark et al 1991: p 306).

The claim for a science base could not be more firmly expressed. There is considerable debate, though, about the benefits of this course of action. Some recognise it as a valuable offshoot of occupational therapy and yet others argue against it, since scarce research resources should be put towards applied theory (Hagedorn 1995). Taylor (2001) challenged the comparison sometimes made with psychology as an example of an academic discipline that emerged from a clinical base and the implication that this served as evidence that science would inform and elevate occupational therapy practice. As a psychologist himself he revealed that the origin of the science of psychology is debate-able and using psychology as an example would, in fact, suggest that occupational therapy practice would not benefit from occupational science. There are those who feel that occupational science will lead to divisions within occupational therapy. Occupational scientists may separate off to pursue higher academic status, for example, leaving occupational therapists to undertake more menial practical activities (Mountain 1998).

Certain sectors remain unconvinced that the general notion of any scientific paradigm is appropriate, preferring to view the development of occupational therapy as evolutionary and flexible in its beliefs and theoretical choices (Hagedorn 1995). Goren (2002) expressed the opinion that many occupational therapists have not 'bought into' scientific concepts. Where did the practitioners stand on this issue?

Thirty percent of practitioners thought that tying practice to science was useful for competition or professional credibility. This view was characterised in the following quote.

OT23 (physical): If we're going down the practical side then you also need some evidence to back up what you're doing... to give you any credibility whatsoever... rather than saying 'I think I should do this'... just because it looks good or it works well. You actually need... some kind of evidence to back you up... so that other professions will see it and think 'well yes they do know what they're doing'. And we've got to stand up and say why we do things.

Fifty three percent thought that it was important to strike a balance between science and practice. This commonly held view was expressed in this extract.

OT6 (mental health): I think you can go to either extreme too far and er I think some of the research [has too much regard] for the theoretical side of things. On the other hand if you concentrate too much on the practical side of things... there's no foundation as to why you do it but you know it works... I think there's a happy medium.

This group would support the work of Jenkins & Brotherton (1995b), who argued that the keystone of theory was practice. They presented a learning-in-practice model of occupational therapy, identifying theory and practice as one entity. The following quote is representative of a strongly held view among the practitioners that when science is used it should focus on the everyday practice of occupational therapy intervention.

OT19 (physical): I feel that there needs to be a really good balance there... where practical skills are given the same importance really. I think there's a place for both and I wouldn't say that, yes you have to be completely practical... and forget the rest. I do agree that there's a place [for science] but... I don't think that we should go down *that* road to the detriment of practical skills at all.

Eleven percent thought that there was pressure to employ scientific research methods, which were inappropriate for occupational therapy, as this respondent reported.

OT31 (community): I think the biggest problem is statistics for OT... In terms of stats and objectives... anything which is subjective is brushed under the carpet, is not valid and I think that's our biggest problem.

Some community occupational therapists reported occasions when it was difficult to document their intervention; no equipment had been provided but the patient had benefited in subtle ways. An episode of care was often judged to be a success when equipment was not provided but the patient had learned to cope. Authors

such as Kelly (1996) have noted that there is a great deal of art in occupational therapy practice. Stewart (1994) and Taylor (1995) made a similar point, adding their voices to the growing body of criticism of the profession's links with the medical model and therefore objective science. Within this model the role of the doctor is to determine the problem, using scientific knowledge, and administer the solution or treatment. The role of the patient is to submit to the doctor's authority and to follow the advice given (Reed & Sanderson 1999). The introduction of client-centred occupational therapy practice, which encourages enablement rather than passive treatment (Wilcock 2002), is at odds with this model. In 1989 Joice & Coia argued that sole allegiance to the medical model would not help the viability of occupational therapy in mental health. The practitioners in this study tended to agree with this viewpoint. Although a scientific alignment was useful for professional image, they considered that the techniques of inquiry should be directly applicable to practice, much of which is inappropriate for laboratory methods.

Theory

In the 1990s there was a return to the activity basis of occupational therapy but with a greater emphasis on the theories linking environment and occupation, to strengthen the scientific orientation. Activities were used within 'models of practice' and 'frames of reference' in order to foster professional unity and growth (Willard & Spackman 1993; Reed & Sanderson 1999). Models currently in practice include: Keilhofner's Model of Human Occupation, based on the concept of occupational dysfunction (Keilhofner 1985); the Biomechanical frame of reference (Pedretti & Pasquinelli 1990); Psychodynamics frame of reference (Fidler & Fidler 1963) and the Neurodevelopmental frame of reference based on sensorimotor theory (Bobath 1978). Reed & Sanderson (1999) list no less than 53 models of practice. It is no wonder that Mocellin (1992) suggested that students were so confused that they modeled themselves, through apprentice-type training on practitioners, who were equally perplexed, the result being that they decided for themselves what occupational therapy was all about. What was the attitude of these practitioners to theory and how helpful was it to their practice?

Goode (1969) claimed that, in daily practice, most professionals did not use much of their esoteric knowledge. Within occupational therapy, Ryan (2001) found theory was not used or valued in practice and objections were made about 'making clients fit into models'. This seemed to be the case for this group. Fifty three percent of practitioners did not consciously use theory in their day to day practice. This widely held view was characterised in this quote.

OT26 (mental health): We're the only profession I know of that's got models of practice... that aren't... they developed at a slow pace... Which either means people aren't using them or... people have just acknowledged them and that's it, they're just lying there unused... and I think that's not healthy

For many, time constraints were the prohibitive factor. There was some support for Foster & Wilding's (2000) claim that modern professionals have become servants of state purposes. In the acute sector the prime aim was often to get patients out of hospital as quickly as possible to meet government targets. In this practitioner's view the work had become very procedural.

OT4 (physical): There's a very, very quick turnover... it's difficult to have to think about it in that way [using theory]... We're just making sure they're safe for discharge and provide the equipment and you know, you've done what you can in a short time... Shouldn't be like that but... I think when you work on an acute ward it *is* that way... It's not traditional OT really is it? It's discharge planning.

Wilding (1982) and Freidson (1970) argued that if professional education was too intellectual, there was a danger of dissatisfaction when students' expectations of the job were not realised. There was an element of that within this group. Fourteen percent thought that the use of the theory raised unrealistic expectations of the job. There were many who found that the speed of patient throughput meant that there was little opportunity of putting anything other than the most basic skills into practice. Characteristically, this practitioner revealed that skills that had been learned at university were underused and the work was different to the way that it had been portrayed.

OT21 (community): I think it's very frustrating...er... you know, because I worked hard. I was an average student, it didn't come easy for me and I worked hard. And I had this idea of what occupational therapy was going to be like... and it is quite a shock when you come out into the big, bad world... and it's very different to what it is on paper.

Too much theory and lack of relevance to real practice was another explanation for this occupational therapist not using it.

OT11 (mental health): There are lots of different models, they don't all match up... some of them are completely off the wall.

Nineteen percent thought that the absence of models of practice was not detrimental to an occupational therapist's ability to do the job, as this practitioner explained.

OT34 (mental health): I think there are also... a lot of people that... although they don't follow a model are still able to perfectly justify and explain their treatment... and it *is* OT focussed... but they're not using a model.

There are, of course, some people who do use theory. Of these, 22% used abstract theory in the form of models. This was restricted to the community and mental health; none of the physical occupational therapists reported using a model. It was

slightly more common to find abstract theory used by junior staff. This practitioner, for example, used a theory that had been studied at university.

OT34 (mental health): The model that I find most useful is MOHO...[Model of Human Occupation] but then again you see... in college I suppose that's the model we went into the most depth... So it's the one I know more of... And I don't use it for everyone but I do find it very, very useful.

Another 11% used an eclectic mix, dipping into several models or created their own adaptations of theories. Interestingly, as for this practitioner, they all came from the mental health field.

OT26 (mental health): I came into the profession with an art background and I knew that I wanted to use creativity as a tool. And I think I sort of... not adapted but... see them in relation to that model of the creative process erm... And I think you can tie things on to that about developing personal choice.

Twenty eight percent used concrete theory (those related to anatomy or conditions, for example), although this did not include any of the mental health occupational therapists. This type of theory was considered useful because it directly applied to the work and facilitated clinical reasoning, a view expressed in the following quote.

OT31 (community): You use that knowledge to know what to look for and it's probably apparent... we... Often care workers here do a lot of OT assessments... or what are in my view OT assessments... erm and they don't have that medical knowledge... And I think that's quite obvious when you get cases like diabetes... and they don't... they're not able to ask... not leading questions but related questions. Like they wouldn't think to ask about... how do they care for their feet? Or do they have any problems with their feet? Or... you know, if somebody with diabetes happens to mention, they assume it's a separate... a completely separate thing... and they don't necessarily think there may be a connection.

The majority of practitioners then, did not use theory and some considered it possible to carry out occupational therapy skills without an abstract theoretical background. The speed with which patients are processed has made the use of theory and some of the skills learned at university redundant. The effect is that the newly qualified have found the work of an occupational therapist to be different from how they imagined. Some, in this study, have found models to be irrelevant to their work, according with a growing band of writers who have been critical of the type of theory linked to occupational therapy. For example, Goren's (2002) view was that some frames of reference have proved to be white elephants. Barnitt (1990) thought that reliance on models, particularly in busy

departments, has led to faulty thinking and inhibited creativity whilst Jenkins & Brotherton (1995b) argued for frames of reference to be anchored within the reality of practice.

Amongst those who did use it, the physical occupational therapists tended to use concrete theory. This is consistent with the work of Tyldesley cited by Woodward (1994), where 95% of occupational therapists thought that the teaching of anatomy was essential to treat patients. It is not surprising that the mental health occupational therapists had a greater tendency towards abstract theory and that those who worked in the community, where the work covers the whole spectrum of problems, used a mixture of both. Some used their own version of a theory rather than strictly adhering to one. Kelly (1994) thought that this tendency to create individual interpretations of models (isomorphs) generates as many models as there are occupational therapists, which further adds to the confusion. The current work culture is one where speed of throughput is the imperative leaving little time for individual judgement and in the opinion of some of this cohort, quality of service provision suffers. A survey revealed that over 60% of professionals allied to medicine did not feel they had sufficient time in their jobs to treat patients to their own satisfaction (Newman 2001). As long as this situation remains unchallenged, occupational therapists are open to the charge that they are colluding with government policy and not acting as advocates for patients.

Mystification

According to occupational ideology, the knowledge that a profession espouses, should be esoteric and the amount and difficulty of acquiring it, sufficiently great, that members of society view the profession as possessing a kind of mystery unobtainable by ordinary people (Goode 1969). Goffman (1969) defined this process of mystification as the tendency to prevent those outside a profession from gaining familiarity with the skill. It was a term used to explain the ways in which an individual or organisation could perform to accentuate certain matters and conceal others, the aim being to draw reverence and deference from the public. Macdonald (1995) made the interesting point that, in the ancient guilds, members achieved a mastery of their trade, which was called a 'mystery' and the masters of the mysteries were beyond challenge in relation to their guild knowledge. The earliest professions, of course, were under the tutelage of the Church and the 'holy mysteries'. A solid scientific base is an example of 'mystique' according to Larson (1977), who suggested that those professions that did not have one tended to rely on unnecessary jargon or unjustifiably esoteric techniques or 'pseudo-paradigmatic' changes. Latterly, there has been criticism of the nature and validity of professional expertise which, when exposed to investigation, has often proved questionable (Illich 1975; Schon 1991; Foster & Wilding 2000).

In recent years numerous theories including those based in behavioural sciences, occupational dysfunction, kinetics, sensory deprivation, human geography,

sociology and anthropology have been introduced into occupational therapy education. There has been an emphasis on clinical reasoning, assessment, frames of reference, approaches and models, to direct the treatment methods (Reed & Sanderson 1999). Each concept carries its own assumptions and techniques of assessment and intervention, all couched in academic terminology. This could be regarded as mystification if the intent was to hide something. It has already been established that the practitioners have ignored the intellectual debate about a definition of occupational therapy and created their own simple understanding. They do not make use of complex theory, relying on straightforward applicable knowledge. So how did they regard the introduction of academic language?

Forty seven percent of the group thought that mystification was evident within occupational therapy language but that it had a role to play in creating a better impression amongst other professionals. This practitioner reflects this viewpoint, whilst indicating that it was regarded as artificial language.

OT36 (physical): I think maybe for the current climate yeah [mystification is necessary]... I think that's probably right, the more you can demonstrate that sort of thing and give it fancy names because that's the name of the game... jargon and titles.

Another 47% thought that 'pseudo-scientific' language was mystification and further, it was not helpful to the profession. Most thought that the British Journal of Occupational Therapy was too scientific, difficult to read and not applicable to practice. Among the reasons given for this view were that jargon was unnecessary for credibility, practitioners found it confusing, other professions were unimpressed and occupational therapists do not need artificial language to be valued. For example,

OT12 (mental health): **I know**... that my role here is valuable so... we don't need... terminology to kind of... help that.

Some thought that over-complicated language could be divisive. This respondent thought that the content of what was being taught in universities was the same as ever but was presented in a more complex way.

OT35 (mental health): I think... a lot of language has gone too pseudo-scientific... I think it also creates a distance between folks who trained a long time ago like I did and the different styles of training that new or relatively new graduates that are coming out. Because we *are* speaking a different language erm... and although it's very easy to say... it's up to date... I think the reality of the situation is... that a lot of... the style of presentation of education that people have to go through has been dressed up in a different sort of way...

This respondent thought that introducing science was counter-productive to the therapeutic process, which was essentially creative.

OT26 (mental health): We get tied up with scientific jargon sometimes and actually a lot of it is about giving people opportunities to try things out they haven't done before and talk through it. And that's a creative process but it sometimes gets converted into a scientific process and we lose [out].

Twenty two percent thought that mystification was concealing the fact that occupational therapy was in essence a simple concept. This view was expressed in the following extract.

OT11 (mental health): I don't think the scientific charge is particularly helpful because it makes... it fairly obvious that what we're trying to do is to take a simple thing and make it incredibly complicated... And that alienates the client... the first issue for me, and it alienates other members of staff... who can quite easily see... what we're doing is very simple and straight forward, it doesn't have to be made complicated.

Although some practitioners thought that mystification might help in impression management and competition, most saw it as the emperor's new clothes. They held the view that it was contrived, pseudo-science, which has not been helpful for the profession or its clientele. It could hide lack of confidence or the fact that occupational therapy was a simple concept but the important point to make is that practitioners had the confidence to claim that their expertise was valuable without the benefit of mystification. Social distance, however, was a different matter.

Social Distance

In Goffman's (1969) opinion, when the intent is to generate awe from an audience, a profession will use social distance to prevent close scrutiny and encourage mystification. Hall (1975) used this idea, arguing that esoteric knowledge was a social distance mechanism in that it kept the public 'away' from the knowledge of professionals, helping to sustain their importance. The need for social distance can be clothed in other, more worthy aims. The client is in a vulnerable situation and is at the mercy of the professional's expertise, creating a danger of exploitation. Professionals are therefore duty bound to avoid emotional attachment, to judge a client's needs dispassionately and to keep the relationship within the limits of the task to be done (Goode 1969). At the same time, if a profession can be surrounded by artificial mystery, in order to deter familiar contact, the audience is more likely to hold an idealised opinion of the profession. This is a Janus headed situation, in Goffman's view, with awe on one side and shame on the other.

The audience senses secret mysteries and powers behind the performance, and the performer senses that his chief secrets are petty ones. As countless folk tales and initiation rites show, often the real secret behind the mystery

is that there really is no mystery; the real problem is to prevent the audience from learning this too. (Goffman 1969: p 76).

Maintaining a social distance with strategies such as doors marked 'private', the use of separate facilities (especially toilets), the use of formal job titles (sister, nurse etc.), and the wearing of a uniform, contributes to the mystification process by preventing close scrutiny. This helps to express the possession of knowledge by the professional and the lack of it by the patient (Hugman 1991). Goffman (1969) considered that there was a ceremonial component to behaviour, which required the individual to create a personal front. The aim would be to get those observing the front to accept the impression that was presented to them. In health care settings patients are offered a performance which is highlighted with expressions of cleanliness and integrity. Aided by social distance, it gives a standardised idea of how all people in health care would behave and it becomes a 'collective representation'. What personal front were the practitioners presenting?

Having expressed distaste for mystification, 61% of practitioners saw social distance in a positive light. It could be used as a defence mechanism, concealing lack of confidence in novices. For some, having separate toilets was a matter of hygiene but there were other reasons for social distance that allied to Goode's justification: avoiding emotional involvement with patients, for example, as this practitioner explained.

OT23 (physical): I think if you get too involved with patients... it can become quite a personal thing... and then I don't know if you actually give your best as a therapist.

It also enabled objective decision-making for this practitioner.

OT13 (community) I *do* think you need a distance sometimes because you're going to have to turn people down and it becomes more difficult to turn people down that you're closer to.

For this respondent, working in a secure unit, it offered some self-protection.

OT30 (mental health): We have to be very careful about what kind of information people know about us... people know very little about you.

The possession of professional expertise and the absence of it in the patient could be emphasised, a view expressed in the following quote.

OT20 (physical): I think yes you do have to maintain some distance because... if a patient doesn't see you as being any different to them... I don't think they will relate their problems... erm... appropriately, not in a physical setting anyway... erm... I think there has to be a difference... otherwise they won't... they're not going to see you... really as a professional.

An experienced therapist, working as a reflective practitioner, assesses body language, voice signals etc and will judge which techniques to adopt in order to gain patients' empathy and trust (Hagedorn 1995). These techniques are all part of the personal front and can be changed rapidly if the situation demands it. Seventy two percent of practitioners gave indications of this type of behaviour. For example, they all preferred patients to call them by their Christian name in order to put the relationship on a more equitable footing. Social acting as described by Goffman (1969) was utilised on occasions. It was more common among the mental health and community occupational therapists where the therapeutic use of self was more likely to be employed. Body language was an important tool, communication out of character was used, and it was necessary to wear clothing that reflected the patient's financial status, the aim being to put the patient at ease. One respondent reported feeling uncomfortable while using an expensive hire car to visit patients in a deprived area. Social acting was often used to demonstrate attributes such as being hard working or selfless or in the case of this practitioner, able to give total commitment to an individual.

OT31 (community): You have to give them the impression that theirs is the only case you're working on, you're interested in and a lot of time, people don't want to know about other things... You're there and you're there for them... and I'm not saying you talk about other cases but the fact that you have got other cases to deal with is very often of no interest to them.

Form of dress was a symbol of social distance that helped an occupational therapist carry a demeanor guided by his or her definition of professional self. It was an important element of personal front intended to convey to the observer that the person they saw, was the person possessing all of the attributes claimed (Goffman 1969). Sixty four percent of practitioners made some comment about the importance of dress. There were some issues of practicality, such as hygiene or comfort and decorum but those who wore a uniform thought that it signified status or authority and was a form of identification. It was symbolic for junior staff, since it acted as a right of passage signifying a transition from student to qualification. Juniors would anticipate that patients expected to be helped by someone with expertise and so they drew confidence in portraying this image through the wearing of a uniform. As this practitioner explained, a uniform could be used in this way, even when it was not a requirement of the job. With experience, confidence grew and the use of a uniform, as a prop, could be discarded.

OT2 (community): A lot of the junior staff actually feel very comfortable even on community... wearing a uniform because you don't actually have to... announce you're presence if you like. Where you go and knock on somebody's door... the uniform does it for you it's that... you know... you're right to entry erm... and I think that's a confidence thing to a certain extent.

From the stance of a senior practitioner the lack of a uniform signified a higher position in the work hierarchy. In the following extract, not wearing a uniform signified that the individual had been elevated from the 'dirty work' aspects of clinical care.

OT2 (community): Because you're *allowed* not to wear a uniform it's a bit the same as erm... doctors the consultant doesn't wear a white coat but the junior doctor loves it.

Thus, depending on the individual's situation, occupational status could be signified both by wearing and not wearing a uniform. Generally, physical health occupational therapists wear uniform, those in mental health do not, and either might be the case for those in the community. For those practitioners that did not wear a uniform there was still a smart code of dress. The intentions were the same as those given for the wearing of a uniform, namely, to demonstrate professional demeanour incorporating status and authoritative expertise. The following practitioner expressed this widely held view.

OT28 (community) I've sometimes thought should I... stop people wearing jeans for example because they don't look... professional and does it mean that... People think that... if you're wearing something like that erm because you don't look like a professional, you haven't got a uniform on, that people haven't got the knowledge, they haven't got the skills.

Practitioners then, were presenting a collective representation of professionalism that involved emotional detachment, objectivity and expertise. They wanted to convey trust, empathy, diligence, selflessness, commitment, authority and status. This was their front stage performance, according to Goffman (1969). It was done through social distance and general demeanour but not pseudo-science.

Personal front and ceremonial behaviour are difficult to sustain on a permanent basis. Hagedorn (1995) recognised that the reflective practitioner role could be difficult and it was much easier to retreat behind the expert practitioner, which, according to Schon (1991) involves a presumption of expert knowledge, social distance and requires deference from the patient. Seventy two percent of practitioners indicated this type of behaviour at times, usually in the form of generating greater social distance. Goffman (1969) argued that the audience contributes to the maintenance of personal front by tactfully accepting that the individual is a person of worth. This practitioner reported a typical view that it was important for patients to be respectful and on occasions it was necessary to remind them to show deference.

OT34 (mental health): Sometimes you will find that they [patients] become sort of over friendly or, you know, or... and then you have to sort

of say... A lot of times I will do it in a joking fashion by sort of saying 'I'm still... you know, I really enjoy working with you etc but I'm still the therapist here and my role is blah, blah... And *this* is not within that'.

Expert, authoritative behaviour was most likely to be employed during difficult encounters, as in this instance when a relative challenged the practitioner's actions.

OT17 (community): I had a phone call this morning... The assessment officer handled it absolutely right... [but] the lady was incredibly abusive to her because her mother was an urgent case well it **isn't** urgent... not the way we call urgent er so I said '**hand it to me**'... And I spoke to her and I made it **quite** clear from **my** training... how... how, you know, I was going to approach this for her.

Goffman (1969) explained that when there is a front stage there is usually a backstage into which outsiders are prevented from entering, so that they do not witness a performance that is not directed to them. The staff room was used as the backstage for these practitioners. It offered an opportunity to socialise, to revert to character; it could be used for relaxation, or respite from work pressures. It was a place where team loyalty prevailed. Secrets that would give the game away could be shared. For example, some patients in forensic psychiatry units have committed terrible crimes but must be treated with equity. The practitioner in this circumstance was able to express personal feelings of revulsion in the safety of the staff room,

OT30 (mental health): We deal with people who've done some pretty horrific things... or experienced some pretty horrific things as well and you have to be able to... process that... You can't process it with them erm and we can't process it outside of the unit either because of the confidentiality factor. But I think to actually... be able to deal with it in an appropriate way you need to process it in some way... just to let it out 'oh God that was really awful'...that's a safe place.

It was so important that people improvised when they did not have access to a staff room. For example,

OT33 (community): I think my haven in the community is my car... If you get a difficult client or an awkward client or an awkward situation you can come back and shout and scream yourself out in the car. And just drive off to another place and chill out for a few minutes or less... before you do another case so again I think it's nice to have a little bit of space

Home, was another backstage arena. The separation of work and home life was essential for 28% of the group. It is not normal practice to divulge telephone numbers and addresses to patients, for example. Whilst there could be a safety

issue, it was more usual that the practitioners did not want their personal and work lives to merge. The intent most often was to avoid damage to the image of themselves as committed, temperate, and responsible people. The importance of this is demonstrated in the following quote.

OT29 (physical): I know that out of hours, if I see patients in the community, they know who I am, especially when I *was* working in community I found that... quite difficult... That Saturday afternoon on town [chuckle]... that you've got to... still portray certain... You've not to be seen doing anything that... could be used against you... 'Oh they're acting recklessly, how can I take them seriously on Monday morning when I've got an appointment?' So I think... being professional doesn't just [mean] throughout the nine to five job, it is throughout because you never know who you're going to see or meet.

This is an example of what Goffman (1967) called avoidance ritual, which allow people to conceal aspects of behaviour that could be deemed undignified. Although mystification was regarded as distasteful, social distance was quite prominent within this group, notwithstanding the idea that it conflicts with reflective practice. In the company of patients, ceremonial behaviour was used to portray a professional demeanor, with attributes of cleanliness, objectivity, expertise, trustworthiness, acceptance, devotion, diligence, selflessness, respectfulness, discipline and possessing good communication and interpersonal skills. A uniform of some sort, either formally provided or the individual's own smart attire (but not necessarily expensive), was used by all practitioners and served a number of purposes. There were some issues of practicality such as hygiene and propriety but it mainly helped to facilitate the front stage performance; expressing status, authority and knowledge. For junior staff it acted as a symbolic right of passage, giving confidence to the wearer. For the experienced a formal uniform was not necessarily needed for this purpose and 'coming out of uniform' could signify upward mobility. Social distance thus offered status and marked an individual's position in the labour market. The return for this presentation was that practitioners would be deemed worthy of deference. This rather saintly manifestation would be difficult for anyone to maintain in the long term and a backstage arena was essential. The prime purpose of social distance therefore, was to conceal from patients the truth: that practitioners have as many foibles as everyone else does.

Value to Society

It is not enough that the expertise of a profession should be based on scientific theory. It must also have value for society whose members should believe that the knowledge could solve their problems of living (Goode 1969; Becker 1977). All occupational ideologies lay great stress on the essential worth of practice (Johnson 1972). Those occupations likely to have most public influence are those that can claim the authority of science and at the same time bring normality back to peoples' lives (Macdonald 1995). As Wilding (1982) has reported it should be,

Knowledge about life and death, mental, physical and social well-being, the healing of individual and social ills and the preservation of the economic and social order (Wilding 1982: p 71).

Freidson (1994) remarked that it must be 'good work' and at the same time clients must have trust in the expertise. He had earlier concluded that the kinds of expertise that are necessary are debate-able (Freidson 1984). Wilding (1982) cited social work as an example of an occupation where doubts have been expressed about the knowledge base and the use to which it can be put in reality. Bennett et al (1973) noted that the primary criticism of service professionals was that their knowledge base was thin and underdeveloped. Professionals, therefore, have to work to get their knowledge base valued.

It has been established that practitioners questioned whether or not science has informed practice and that the skill was not difficult to learn but this did not mean they thought occupational therapy had no value. Their personal front emphasised that they had something worthwhile to offer. Forty four percent of the practitioners' responses made specific reference to the importance of occupational therapy in returning some normality to an individual's daily life. It was often the most basic of needs that were being addressed but as such they were of the highest priority. For example,

OT32 (community): When you're working as an occupational therapist at the end of the day it boils down to the bread and butter stuff... and what people feel that are essential in their lives... And it's essential to get on and off the toilet; it's essential to feed yourself, and all those sorts of things.

For this group, the essence of practice continues to be enabling people to overcome difficulties in coping with daily life. Although it is not knowledge about life and death these occupational therapists believe that their skill is imperative for their clientele. In this they have shown alignment to those authors who argued that occupational therapists should recognise, and be proud of, the value of their work, and the simplicity of the premise that activity and wellbeing are linked (Barnitt 1990; Fortune 2000). Holder (2001), for example, made the point that simple concepts still have a significant impact on health and Creek (1999) argued that being useful was more important than being powerful for the survival of occupational therapy.

Ownership of Professional Knowledge

Ownership of a highly developed body of knowledge is a crucial factor in an occupation's claim for professional status; for example, doctors own the knowledge related to medicine, with society judging the knowledge of nurses and pharmacists to be ancillary (Goode 1969). Reed & Sanderson (1999) recognised the problems that working within a medical model posed for occupational therapists. They do not treat disease or injury but rather the residual effects, and

the relationship between patient and therapist is less authoritarian than that of doctors, emphasising instead, self-responsibility. Following this line of analysis, society would place the value of occupational therapists' knowledge, fairly low down in the hierarchy. Creek (1997) supposed that helping someone to regain independence in self-care was a low status activity compared with diagnosing and curing disease.

The knowledge base of occupational therapy will always be viewed as thin if judged next to that of a doctor. It may be, therefore, that comparisons with the knowledge base of medicine should cease. Rather than changing practice in order to fit in with a medical/scientific model Creek (1997) presented a case for occupational therapists to choose to retain their unique approach and work towards having it understood and valued by others in its own right. The practitioners agreed with the premise that occupational therapy cannot be based on abstract scientific principles, nor should it. They believed that qualitative rather than quantitative research was more likely to reveal the value of the profession. The following extract is representative of this common opinion.

OT11 (mental health): I think that the debate about where the evidence comes from has to be widened out erm... We have to look at social studies and things like... obtaining the erm... necessary kudos if you like to be allowed to do the research in sufficient quantities. To be funded at **that** and to pursue through further education those kind of issues in order to widen out the scope of the profession purely in terms of 'scientific methods', which is not scientific in the first place erm, are impossible to even produce. We don't operate in a laboratory we operate in the community so it's crazy to apply... particularly in the field of psychiatry... where we're looking at social function... methods, which aren't derived from the laboratory.

Hall (1975) recognised that professions have disputes with respect to the appropriate theoretical perspective and he raised an important question regarding who owned professional knowledge. If a decision was made to disassociate occupational therapy knowledge from that of medicine and claim ownership of something different how would that decision come about? Where did the practitioners believe the power lay, in deciding what the work of an occupational therapist was, the organisational body or the practitioners?

Thirty-nine percent of practitioners believed that the College of Occupational Therapists (COT) had some influence in establishing ownership of professional knowledge, as this practitioner reported.

OT25 (community) I would say that because they [COT] are our professional body they have got quite a bit of weight really... deciding how we as a profession develop and work.

In contrast 56% thought that COT had little power in deciding what the work of an occupational therapist should be. This respondent reflected the widely held view that COT was distant from practitioners and had little understanding of their issues.

OT34 (mental health): I think... the College of OT or whatever are getting so carried away in trying to move forward... rather than actually stopping and getting down to the basics of what we're all about... I think they get caught up into... professional development without actually having the roots to develop from.

Many considered that in practice, it was practitioners who decided what the work of an occupational therapist was, a point made in the following quote.

OT1 (physical): I think it's... a lot of it is down to local negotiations erm... and really custom and practice as to what has been going on.

Others, (39%), wanted COT to take more control. In the opinion of this practitioner, occupational therapists had too much freedom to work outside of professional boundaries.

OT24 (community) I think they [COT] should give guidelines. I think there are some OT's that are practising as OT's but they're not doing the job of an OT... Or not carrying out things that are... what I call core businesses I suppose or what we call... or what OT's have been set up for at the start.

In brief, the practitioners believed that occupational therapy does have a unique skill, which is not difficult to learn. A scientific orientation would only be successful if it related directly to practice. They regarded their skill to have value to society but the association with medicine and scientific ideology could be counter-productive in that it deviated away from methods of inquiry that would reveal its true worth. Most did not use theory because there were too many, they were irrelevant, practitioners were too busy and they could perform just as well without them. Mystification was considered to be detrimental but social distance was necessary to put up a personal front that was designed to evoke deference from patients. Practitioners held strong views about professional knowledge but COT was considered out of touch with their perceptions. There was a call for greater COT ownership, with central control to place boundaries around and protect the unique skill of occupational therapy. This was the practitioners' view: the next group to be asked about monopoly of knowledge was the seven representatives from the College of Occupational Therapists (COT).

THE VIEWPOINT OF the COLLEGE of OCCUPATIONAL THERAPISTS

Professional Skill

Interestingly, if a new occupational group wants to prove eligibility for regulation under the Health Professions Act (Department of Health 1999), it must 'cover a discrete area of activity displaying some homogeneity' (*Health Professions Council 2002). The initial response from three COT respondents revealed that they were unconvinced occupational therapy has a discrete area or a unique skill. The overlap with other professions was pointed out in this quote.

COT6: I've thought about this quite a lot... there's a tremendous amount of overlap between the professions physio's and OT's and social workers.

But the emphasis on occupation or analysis of behaviour was made in the following quotes.

COT1: I think it's the focus on humans as occupational beings and helping people to retain their occupational capacities that makes us unique.

COT2: Helping people to change their behaviour to maximise their quality of life within the limitations...set.

Two respondents thought that it was the client-centred approach of occupational therapists that is unique, as this quote explains.

COT7: I do genuinely believe that the role of occupational therapists is to look at... not just the person and what's happened to them and their trauma that they're facing in their disability but actually listen... to what they want to achieve.

There was recognition that the skill of occupational therapists has been subject to change, for reasons of status, and that this has not always been beneficial. For example this respondent made the point that occupation or activity has been undermined.

COT1: I think the only thing that I would see as unique is... is the thing that I think is central is the thing we devalue most... in the past [what] we've valued most is the emphasis on occupation.

*When the Professions Supplementary to Medicine Act (Department of Health 1960) was reviewed the opportunity was taken to modernise professional self-regulation. The Health Professions Council (HPC) came into operation in 2003 to replace the Council for Professions Supplementary to Medicine (CPSM). The HPC was created to set standards, approve courses, keep a register of health professionals and take action against registrants who do not meet the required standards (Health Professions Council 2003).

This respondent thought that, by introducing more prestigious interventions, patient groups who were in greater need were denied access to help.

COT2: There's been too much concentration on er peripheral skills... again to raise status and particularly the flavour of the month or year... Cognitive behavioural therapy and dieting management and relaxation er these are important but if we thought about the core... of what we do because I think helping people with their daily lives and their... occupations to use the... the jargon er that would be helpful... An example is for instance in mental health... Where in mental health units it's known there's been a shift towards helping people who perhaps aren't as severely ill...er but occupational therapists have a great deal to offer those people with severe mental health problems they need a lot of help with day to day life.

Whilst most agreed that the skill of occupational therapists is based on occupation and analysis of behaviour, almost half of the COT representatives did not consider the skill to be unique. They were not quite sure what skill was 'owned' by occupational therapists. Others thought that it had more to do with approach and there was some concern about the effects of change, in the interests of status, to the skill base. There was an understanding that in trying to get rid of activity, as the unique skill there was a gap that had yet to be filled. This respondent summed it up,

COT7: Well... I think one of the reasons why we're in such a quandary and people keep on saying 'well nobody knows what we do' is because we don't know what we do ourselves.

It could be argued, on the basis of these findings, that practitioners *do* know what they do. The practitioners were more confident and had a stronger idea of the nature of their skill base and the ways in which it was different from that of other professions. They had a clear view, untroubled by rhetoric; occupational therapy has a straightforward but worthwhile expertise to offer.

Linking Professional Knowledge to Science

There was a general belief that models of practice and linking with scientific ideology were necessary for the promotion of professional status, a view expressed in the following quote.

COT3: I suppose in a way it's also to increase er the status of what... occupational therapists do that we're not just... doing it there's a purpose behind and they're following a particular approach.

Almost all of the COT respondents, when asked about the ways in which occupational therapy practice was being tied to science mentioned the adoption of occupational science. The following quote was typical.

COT7: Because we don't have... a profession specific theory and certainly people say as long as you know your anatomy and biology... biological things and your psychology then... you'll just pick up by osmosis... the rest of what being an occupational therapist is... And I don't believe that I think we have to... be able to understand... why occupational therapy works... and to be able to do that we need our own theory... and I think that occupational science is a way of developing a science based practice.

This COT respondent thought that models were useful for novice practitioners.

COT7: Lots of practitioners will say 'ah yes but it's all in my head' and it is how I work, like I said that is how I work and it is all in my head but... Students haven't got it all there and we can't wait ten years while they get it so in fact models of practice... without being too prescriptive, without stopping people thinking... provides a way of marshalling their thought into... into the thinking of a more experienced practitioner.

Dreyfus & Dreyfus (1986) developed a model of skill acquisition, based on the work of Benner (1984), that identified a developmental continuum for growth that involved five career stages: novice, advanced beginner, competent, proficient and expert. Gradually, practitioners learn to respond to problems in increasingly complex ways. The stages represent a continuum, along which progress is made as different situations are encountered. A novice has little experience upon which to draw and is more dependent on standard routines to follow, prior to action. An expert is able to respond quickly and likely to act intuitively, using the lessons learned from previous similar experiences. Eraut (2000) saw this as an exemplar of what he distinguished as the intuitive mode of cognition, which relies on prior experience rather than theory or research and makes significant use of tacit knowledge. The suggestion from the last respondent was that models provided the necessary rules, which would speed up the development of clinical reasoning. However, the practitioners did not make good use of models; of the practitioners that used them some were juniors but the basis of the Dreyfus & Dreyfus argument is that the building of clinical reasoning takes time. There are no short cuts.

As the COT respondents reflected on the adoption of a scientific ideology it became apparent that they shared the same concerns as the practitioners. They understood that practitioners wanted research to be embedded in practice. This respondent pointed out that science may not be informing practice or providing evidence of the value of occupational therapy.

COT1: On one level you could argue, well you don't need, do you, need the science... to practice. Do most practitioners refer to science...? Do you need it to provide a theoretical framework for interventions or for research or to... help people understand, who are training, what the profession is?

Erm...(3)... I suppose I have reservations... particularly with some things like models of practice because I think they... they mainly focus on process and help therapists feel better, they don't necessarily provide convincing evidence what they do makes a difference... I think that's the sort of scientific evidence that we need if the services are not going to be... If there's going to be a future... it's the evidence that what we do works or what we do doesn't work and therefore we stop doing that is more convincing.

There was a belief that theories from outside the UK, particularly those from the USA, should be examined more closely to determine whether they cross the cultural divide. The failure to do so in the past was a cause for criticism for this respondent.

COT2: UK occupational therapists should be more critical of that agenda from the states as indeed I think they should have been more critical of the er Kielhoffner... movement as well. Rather than just thinking 'oh here's a handle we've got something to hang our hat on our ideas on we can present a... some jargon and sound important'. And we weren't critical enough when that came and we're still not critical enough of what's going on.

This respondent accepted that the British Journal of Occupational Therapy was often of more interest to academics than the practicing practitioners.

COT5: To be honest if I think about it, it is something which has become a lot more scientific and looking for more measurable forms erm... But if you look at the people who are actually publishing in the journal a lot... there isn't... very few are practice based... I know that they are practice based but the... usually [it's] academics that would actually... seek to find out more and it's about making it more practically based.

Another respondent was interested in occupational science but could foresee consequences. For example, it may lead to two tiers of occupational therapist.

COT2: Well that's a bit of a double-edged sword because I... There's one argument... the development of occupational science is an attempt to... erm... emphasise the professionalism... aspect... So by... putting a lot of jargon in and creating a lot of theory... and creating a lot of people that call themselves occupational scientists... then we're developing superior sort of... level in the profession. Which may indeed split off and say 'we don't want anything to do with practitioners we're all academics and we're going to you know develop these theories'.

Questions were asked about appropriate terminology but the inference was that the responsibility for research lay with practitioners as far as this respondent was concerned.

COT7: Are we really... wanting to use words like 'occupation' or do we want to use words like 'purposeful activity' and what's the difference between those words? I think... I sometimes feel... where are the people who are doing that...? You know... And I suppose you could say 'well *you* should be doing it' but you know there's a large group of people working on those sort of issues in the States and in Canada and we don't seem to have a large group of people pursuing that body of knowledge.

The COT representatives, influenced by the dominance of scientific ideology, agreed that it could be beneficial for the status of occupational therapy. They espoused the discipline of occupational science although there were reservations that it could be divisive. Models of practice and so on, seen as mystiques by practitioners, were regarded as valuable for novice practitioners. At the same time there was an understanding that the British Journal of Occupational Therapy has become more scientific, that linguistic dispute about 'occupation' and 'activity' was unhelpful, that research should be embedded in practice, and that theory has been accepted unquestioningly.

Role of the College of Occupational Therapists

The COT representatives identified their roles as raising standards, giving advice on ethical issues, initiating and disseminating research, publishing academic publications and the marketing of the profession. There was a belief that the professional body should get involved in government policy and demonstrate the ways in which occupational therapy could assist its implementation. The importance of this was made in the following extract.

COT6: I think it's about... erm picking up on government policy... Policy around things like rehabilitation, welfare to work and all those sorts of things making clear links between what occupational therapists' do and how government can profit... from using occupational therapists and their outcomes.

However, some respondents were concerned about the way in which COT responded to policy initiatives. The inference in this quote was that COT was not acting in the best interests of patients in failing to act as advocates during the early stages of policy development.

COT2: I think as a profession this is one of the areas where we've been particularly slow is in responding to policy or being proactive in policy agreements. I think that's particularly been poor so we'd wait for [policies] to come down from on high without er making the initiative...

particularly the rehabilitation agenda that's around at the moment... policies...things could be a lot stronger there.

Ownership

The respondents were keen for members to understand that COT belonged to practitioners, an aim expressed in this quote.

COT5: Giving them [practitioners] a good understanding erm what their professional organisation is about, improving their knowledge of the organisation knowing that it's theirs and the sense of ownership to it.

Despite this intention a large section of practitioners did not share that view. They considered that the promotion of science by COT had led practitioners and the organisation down divergent paths. Practitioners have ignored occupational science, theoretical perspectives were largely unused, the journal was unread and positivist methods of research were considered inappropriate. Such concerns have not gone unnoticed at COT. The opinion expressed in this quote was that the professional body has become distant from the needs of the membership.

COT7: Perhaps the work of the College has not always pulled together... to give enough remit to the profession out there and to actually help occupational therapists.

As far as COT was concerned, securing a more scientific basis for the profession was in the interests of a higher profile. However, they had similar concerns to the practitioners. Science must inform practice and experience so far has shown that it may not produce the right kind of evidence. Theories need greater analysis, particularly occupational science, which could be divisive. There was recognition that the British Journal of Occupational Therapy needed to be more practice based. Some observed that COT has become distant from practitioner needs and should be more proactive in responding to government initiatives. The drive towards science therefore was a two-edged sword.

In order to look at it from yet another angle, four educators were asked for their views on monopoly of knowledge.

THE VIEWPOINT OF EDUCATORS

Professional Skill

Two educators did not consider that there is a skill unique to occupational therapy but they stressed the importance of activity and function. There is an inference in the following quote that occupational therapists have lost sight of this simple premise.

T1: I don't know if we have any unique skill... erm. But I think we have erm unique skills... erm... And I think one of them is... is our use of activity... erm... and our understanding about the importance of occupation... and activity... to peoples'... daily lives...(2)... and I think that's really an important aspect that we're a bit in danger of losing.

Two respondents did think the skill is unique and highlighted function or occupation, a point made in the following quote.

T4: Well...we actually believe... that...(2)... a person's... health... physical... psychological...(1)...spiritual et cetera... is... Depends a lot... on... the ability to do the things...(3)... occupation ... (2)... So we believe that occupation is essential to well being.

Most considered that the skill was difficult to learn. In this extract the unseen complexities were emphasised.

T3: People see...(1)... the outcome... and... a lot of what... is the complexity... of it... is not visible... unless you make it overtly visible... as we try to do sometimes in the students training... with artificial situations... The actual... analytical... investigative... issues... are not always... clearly visible to outsiders... they see the solution... and they think... 'Well I could've... thought that through...' What they don't see is all the processes that have gone into... determining that solution.

The educators reflected an image of expertise that was to be expected from university personnel, emphasising complexity and the need to apply judgement. They also illuminated another difficulty pertinent to the skill of occupational therapists. There is a sense in which most occupations have expertise, however simple the task they perform: building a dry stone wall, for example appears to involve nothing more complicated than placing stones on top of one and other but it takes great skill. Dramatisation of work is an integral part of impression management according to Goffman (1969) but this is not easy for some service professions. The work of surgical nursing staff is visibly dramatic, monitoring hi-tech equipment and so on whilst in contrast, medical nursing staff appear less impressive when they chat to patients although they may, in fact, be observing breathing, skin colour and a host of other things (Goffman 1969). The same problem can be applied to occupational therapy; watching someone making a cup

of tea or get dressed looks simple but the therapist will be observing a range of cognitive and motor abilities.

Linking Professional Knowledge to Science

Two respondents saw benefits of tying practice to science in terms of improved status, a point made in this quote.

T3: We have looked at... em... professional models... and looked at how they linked to... theoretical approaches... such as the behavioural approach...(1)... neurodevelopmental... bio-mechanical... and how we relate those back... to the basis of occupation...(1)... And I think that... has... moved the profession forward... in having its... professional identity.

However, two educators thought that too great a link with science in the past had disassociated occupational therapy from its claim to having a unique skill base because it has forced the move away from creative activity, as the following extract shows.

T3: We lost... some of our basic...(1)... premise... of... occupational therapy... and went... perhaps... too... medical model... and scientific...(1)... at the expense of our true objective.

Both respondents, however, thought that the profession had resisted becoming too scientific, a point made in this quote.

T2: I never think OT fell... as deeply into that [science] trap... as they did in other countries... America... obviously... em I... don't think we did follow... as far down that route... as they did... but we too have turned back in the other direction... em... er and away from er... more scientific er... theory.

Three educators reflected the on-going debate about the applicability of occupational science. The arguments are summed up in the following quote.

T3: It still is... a little bit of the crossroads... because we haven't truly... got underneath... uhm... the scientific... exploration of occupation...(1)... And I think now... all the debate that is going on... and all the move with the coming forward with... occupational science... as to whether, in fact, it is an occupational therapy...(1)... theory... or whether it is a broader theory which occupational therapists are part of... I don't think that dilemma... is fully... explored... is... something that we need to continue... to explore... and investigate.

Two respondents saw the scientific orientation of theory as pseudo-science, couching the basic tenets of occupational therapy in jargon. This educator saw it as a form of mystification.

T1: About the... mid-to-late-eighties we got Gary [Kielhoffner] coming over from America... and doing his introductory lectures on model of human occupation and it was like a complete... surge of empathy and [everybody] got really enthusiastic because they were all getting very disillusioned I think and... suddenly it was... [Oh look at him] he's the new messiah he's leading us back to, you know, activity and occupation and... I mean some of us had never left but em...(1)... it, you know, and we're saying... but... we've been saying what he's... saying we should do for years, you know, all he's done is kind of repackaged it.

The educators acknowledged that there were too many theories and that it was confusing for students. There was criticism from this respondent that new theoretical innovations, which were often rehashes of previous work, were introduced without being subject to academic scrutiny.

T2: I quite strongly feel... that it should be limited... Only a certain amount of models should be accepted... at the moment anybody who can get a model published... *can* get it published... and people draw together little bits of other models... and say... and add just one thing.

A further consequence of having so many theories is that they hold conflicting belief systems and therefore scientific methods of inquiry would suit some but not all. For example,

T2: [Humanist theory believes] that there is more to life than what you do and what you say and what you think... em... Whereas... perhaps behavioural theory is... depends more on... goes more for... all that matters... there's what you can measure and what you can see.

One educator thought that a scientific approach was not applicable to occupational therapy.

T4: I mean I don't think it is... I don't think we ever will be...(2)... scientific...(2)... when you're dealing with people... you can't be scientific...(1)... because everybody is different.

The educators then, thought that occupational therapy skill was difficult to learn but its complexity was invisible to society. However, their opinion about scientific orientation was conflicting. On one hand it was beneficial for professional status but on the other it had created uncertainty about the unique skill base. In the past, the drive towards science had gone too far but this was now being re-appraised, although one educator thought that science was wholly

inappropriate for the profession. Occupational science, hailed by COT, was worthy of further questioning but its value had yet to be proven. In their view, too many theories have been introduced without the benefit of critical analysis. One of the effects, apart from confusion, is that scientific research methods would not be appropriate in all cases: humanist theory was given as an example of intervention that could not be measured objectively. Some theories were regarded as pseudo-scientific mystiques. In essence, they thought that some aspects of scientific endeavour were deliberately manufactured, which could interfere with progress.

Finally, the viewpoint was sought of three representatives from the Council for the Professions Supplementary to Medicine (CPSM).

THE VIEWPOINT OF the COUNCIL for the PROFESSIONS SUPPLEMENTARY to MEDICINE

Professional Skill

One respondent thought that occupational therapy should have a unique skill but was unable to pinpoint it. This respondent though, was quite happy to use the term 'activity' when defining the skill of occupational therapists.

CPSM2: ...(3)...I don't think there's any other professional group which actually looks at lifestyle and all the activities within lifestyle in the same way that occupational therapists do in terms of analysing those activities as they... impact on the individual.

Linking Professional Knowledge to Science

It is easy to understand the pressure to accord with science when the following comment from a member of CPSM is considered. From this viewpoint, science and the professions are inextricably linked.

CPSM1: That relates back to why medicine is a science rather than an art... And... the decision to adopt scientific method... The way it turns up... very much in detail is the willingness to accept evidence based research of the effectiveness of outcomes and treatment... And that's an absolutely crucial touchstone and the difference between a profession as we would define it and... an activity which merely purports to being a profession and has no interest in scientific research.

However, this respondent highlighted the idea that there is an art dimension to occupational therapy.

CPSM3: There is... an ability which relates to what one would regard more as an art dimension which is more... personal and emotional and... existential... which is I think rather different to all the other professions.

Another respondent acknowledged that pure scientific research was therefore difficult for occupational therapists.

CPSM2: I think there's an awful lot that occupational therapists do... which is very difficult to... scientifically... validate erm... An awful lot of what we do can't be done by standardised norms erm you can't do double blind experimental things because an awful lot of what we do depends upon us enabling and facilitating... individuals and you can't... you can't measure that scientifically. But I think it is important to find ways of... demonstrating that what we do is clinically effective in whatever field we work... erm and I think the profession is still struggling with that.

There was an assumption that occupational therapy had a unique skill but CPSM was somewhat removed from debates about what it was. Science and professionalism go hand in hand but there was an understanding that occupational therapy had more of an art dimension than other professions. This might lead to problems in providing acceptable research evidence.

SUMMARY AND DISCUSSION

One of the main points of interest is the practitioners' perception of professional self with regard to the skill base. They agreed that occupational therapists have a unique skill, which they identified as the resolution or adaptation to functional deficits through the use of activity or analysis of behaviour. But rather than being involved in complex or academic explanations they had a simplified definition of occupational therapy. Few thought that it was a difficult skill to learn. It required practise, common sense and aptitude but it could be learned by almost anyone. Occupational therapy was not considered to be esoteric. COT representatives, in contrast, were reluctant to declare the uniqueness of the skill base, the CPSM representatives assumed there was a unique skill and the educators were divided. Educators considered that it was difficult to learn but highlighted the problems in making the complex aspects of the skill visible to an audience that only saw occupational therapists watching people get dressed. The practitioners, COT and educators all alluded to the idea that the rejection of craftwork had created insecurity about what skill was being claimed for occupational therapy. Semantic debate about 'occupation' and 'activity' did not help. This could de-stabilise the original claim to 'profession'. Traditionally, one of the functions of the professional association was to promote the uniqueness and to place boundaries around the expertise it advocates (Larson 1977). There was little evidence that this was the case for COT.

COT has tried to establish a scientific base to underpin the profession. This was in response to the strong influence of doctors and the recognition that the rise of a profession depended on its links with the dominant ideological structure of the time, in this case, scientific knowledge (Hugman 1991; Larson 1977). The majority of practitioners accepted that tying practice to science might be beneficial for credibility and competition but they thought that it was important to strike a balance between science and practice. Practice, however, should take the fore. They had concerns that scientific ideology did not sit easily with an artistically skilled profession. The group was torn between understanding the need, or feeling under pressure to follow the lead of other reference groups to make links with science, and the realisation that this can hinder as well as help practice. The implication was that positivist research methods were not appropriate and that the true value of occupational therapy was submerged in the quagmire of science. There was an assumption by CPSM representatives that science and professionalism are linked but they agreed that this might create difficulties for a profession with a strong art dimension.

COT representatives and educators thought that science was necessary for professional status. If COT were claiming ownership to anything it was the discipline of occupational science. The focus was on the value of objective science, yet not a single practitioner mentioned occupational science as being necessary for practice. Rather than scientific disciplines, occupational science is based on human geography, sociology and anthropology. It may be misleading to call it a science but most people assume that it leads to positivistic research methods. COT members did raise concerns related to a scientific orientation: the journal may not be informing practitioners, occupational science has cons as well as pros, and there should be more critical appraisal of theoretical frameworks. Research should be based in practice but using the theoretical models available has not so far produced convincing evidence and debates about terminology are on going. The educators thought that tying practice to science has undermined the value of the skill base, with some aspects of the scientific orientation being regarded as mystification. Whether or not occupational science informs practice and the dilemma regarding positivism in research are difficulties that have yet to be resolved.

Scientific endeavour has generated a wealth of theories but nevertheless most were unused by practitioners, who saw them as pseudo-scientific mystiques. COT members saw theoretical models as a quick route to professional experience, although this is doubtful. Among the educators' concerns was the idea that too many theories were introduced without circumspection. Mystification and pseudo-science obscured the fact that theory was not informing practice. Practitioners thought that too much theory raised unrealistic expectations of what the job would be like. Some found that they lacked relevance or did not fit practice needs and the job could be done just as easily without it. Others had configured their own versions. Concrete theory, which informed practice, was considered most beneficial. The realities of the workplace and government pressures to increase the throughput of patients have also made it difficult to use theory in practice. One of the recurring themes mentioned by both practitioners and educators was dissatisfaction with the tendency for occupational therapists to be employed largely as facilitators of rapid discharge, which concentrated their efforts on assessment rather than treatment. They have, unwittingly, become servants of the state in assisting the discharge of patients 'sicker and quicker'.

Mountain (1998) took issue with this, arguing that this type of activity was undertaken because it was at the request of a doctor and was considered to be helpful for status. As a result the needs of patients were compromised. She considered that acquiescence to such activity compounded the more negative aspects of professionalism. This may be true but the practitioners in this study were not undertaking this activity for reasons of status but because they felt impotent to change the situation. They wanted to treat patients as well as assess them but they put the onus for change on the professional body. The COT representatives thought that it *should* get more involved in government policy but that it had been slow to respond in the past. Mountain (1998) argued that the

professional body must shape policy implementation and facilitate dissemination of policy decisions to managers and practitioners but she was critical of occupational therapists whose knowledge of policy and its relation to practice was poor. There are opportunities to become active in policy making for the benefit of patients but COT, educators and practitioners are all responsible for increasing their knowledge of policy and the influence it has on practice (Mountain 2001).

The practitioners were fully aware that academic language, given greatest expression in the *British Journal of Occupational Therapy* was being used as a mystique. Some thought that it was unnecessary and unhelpful but that it helped to create a good impression and was beneficial for competition. No one believed it evoked reverence from patients but was hiding the fact that the concept of occupational therapy is a simple one. Some practitioners agreed with those who supposed that by attempting to 'dress up' occupational therapy in scientific language, the profession perpetuated subordination to the dominant power group of medicine (Creek 1997). Social distance, on the other hand, was used extensively. It was necessary for emotional detachment, objectivity and self-protection but also to create a carefully crafted image: the personal front, of a reflective practitioner, evoking trust and indicating expertise. It was intended to convey diligence, selflessness, commitment and self-discipline. Form of dress was used as a social distance instrument for the entire group. Those in formal uniform intended it to symbolise the attributes of cleanliness, decorum, status, authority, and identity, signifying a qualified member of staff with expertise. Coming 'out of uniform' symbolised career elevation. Those who did not wear an official uniform still used a formal dress code, which to all intents and purposes served the same function. The return for all of this effort was deference from the patient. When deference was not being shown, practitioners tended to increase their social distance by demonstrating authoritative behaviour. It is difficult to keep up a personal front in the long term. To preserve the image, there were a number of back stage arenas where it was safe to allow the front to drop. The staff room, for example, was a place to socialise, express things that should be kept secret from patients and revert to character. It was also necessary to keep home life separate from work to avoid any risk of damage to the professional demeanour. Social distance was, in part, a concealing mystique that practitioners used to hide the fact that they were imperfect icons of virtue.

The knowledge base of occupational therapy is dynamic and changing as the profession strives for upward mobility. Other professions are doing exactly the same and there is no room for complacency, it is a competitive world. The practitioners were ambiguous about tying practice to science, regarding it as contrived. Occupational therapy does not deal with life or death issues and was quite straightforward but they were confident that the skill was valuable to society. The Blom-Cooper Report (1989) highlighted many tributes to the value of the contribution of occupational therapy to health care but confirmed that the persistence of outdated stereotypes of what the work entailed was damaging to

the status it was accorded. The report identified the lack of research designed to evaluate the effectiveness of occupational therapy interventions as a major weakness; contributing to the drive towards science. But it needs to be the right sort of research using an appropriate epistemology.

Taylor (1995) thought that the adoption of scientific methods, despite having the capacity to increase status in the masculine world of medicine, could devalue the work of occupational therapists in dealing with everyday functioning. The perception that science is the only source of knowledge is now being challenged.

It remains unclear what is convincing health, social and educational institutions to continue purchasing such an amorphous and unquantifiable professional service. That they do, suggests that other variables influence the market and other forms of conviction are as powerful as statistics (Goren 2002: p 476).

It is interesting to note that, in 1973 Bennett et al questioned the notion that there was only one type of knowledge (scientific) as it relates to work. Other types, including intuitive knowledge, interpersonal skills, techniques of helping and so on, can be equally as worthy. They argued that service professions are more involved in bringing about change in the client, transferring knowledge, to encourage enablement. This is a unique type of knowledge, which they called 'anthropogical'. It can be valuable and is fundamentally absent in medicine. It is different to the scientific knowledge that would help a doctor deal with a diseased kidney but much more appropriate for dealing with someone with a mental health problem, for example. This bears some relation to the work of Jenkins & Brotherton (1995c) who put the case forward for a new type of professionalism which emphasised practical knowledge that could be shared by patients, allowing a mutual exchange of experience and thus decentralising expert knowledge. Their argument for 'democratic professionalism' would, in their opinion, enhance the value of occupational therapy both in the eyes of patients and society. Similarly, Schon (1991) has argued that research and practice tend to follow separate paths and advocated the use of reflective research integrated into reflective practice. The suggestion was that the reflective researcher and practitioner should collaborate so that the researcher gains an inside view of the experience of practice and the practitioner draws on the researcher as an aid to personal reflection-in-action (Schon 1991). This, he argued, was more beneficial for practice-orientated professions than research methods associated with applied science. All of the groups in this study agreed that such thinking was applicable to occupational therapy.

The knowledge base of occupational therapists is being scrutinised as never before, but as long as the association with medicine continues, they are unlikely to be valued in the same way as doctors. That does not mean that they do not have value. In order to claim ownership of a unique and worthy knowledge base it might be necessary to create some distance from science and cut the links with

medicine. Practitioners hoped that COT would have the power to do this but they feared that grass root opinion was being ignored. They thought that illuminating the worth of occupational therapy was more important than tying practice to science and by concentrating on the latter, the professional association was, in fact, undermining the worth of practice. Given that this is the case, the extent to which efforts are made to align occupational therapy with abstract theory needs to be challenged. Practitioners wanted status and went to great lengths to invoke deference from patients but the debate about whether it should be derived from scientific orientation or the intrinsic value of the work has yet to be resolved. COT thought that the necessary research was the responsibility of the practicing membership rather than the professional body. Mountain (2001) insists though, that it falls on all levels of the profession; practitioners, managers, educators and the professional body to undertake such work.

In summary, the groups had different interpretations of the knowledge base for occupational therapy. Practitioners identified the unique skill as the resolution of functional problems with the aim of improving independence. They expected the professional body to protect the uniqueness of the skill base but COT was less convinced. It would be interesting, if the professional body was to apply now, as new professions are required to do, for regulation under the Health Professions Act (Department of Health 1999), what it would declare as the discrete area of activity. Educators placed the greatest emphasis on the complexities of the skill and CPSM highlighted the importance of having possession of a unique skill. Practitioners realised that a scientific orientation offers credibility but there has to be a balance. Too much science can be counter-productive because it leads to inappropriate research and theory development, practitioners are unable or unwilling to apply theory in practice and it raises unrealistic expectations of the job.

There was an expectation among COT representatives that further adherence to science should continue but this was set against individuals interpreting this as mystification and pseudo-science. Educators understood that too much emphasis on science carried the risk of the profession losing sight of the simplicity of the skill. CPSM had a strong belief in the importance of science but there was recognition that there is an art dimension to occupational therapy and whilst it is important to evaluate the effectiveness of intervention, scientific methods are not always appropriate. Practitioners wanted to be held in esteem and used social distance to portray a personal front aimed at gaining deference from patients. Yet they wanted that deference to be evoked because of their expertise, which was real and of value, not pseudo-expertise. The role of COT followed traditional lines, raising standards and so on. However, there was acknowledgement of difficulties in the relationship between practitioners and the professional body. There was a collective aspiration to work for and on behalf of practitioners and also patients but there was tardiness in responding to government policy making, the result being that COT has become distant from the needs of practitioners.

The monopolisation of a knowledge base is an integral part of the professional project; described by Larson (1977) but according to these data, in the case of occupational therapy it is a shaky foundation. Nevertheless, the skill needs to be standardised to make it a marketable product. This is implemented through the education system; the ways in which it does so will be explained in the next chapter.

CHAPTER 5 – FINDINGS

Data showing the initial coding and categories for control of training into professional practice are presented in Appendix 7.

CONTROL OF TRAINING INTO PROFESSIONAL PRACTICE

In Medieval times those occupations that developed into the classical professions, law, ministry and medicine were associated with the Church and universities. The most superior Faculties were those of Theology, Canon Law, Civil Law and Medicine. Only Cambridge and Oxford universities, who took recruits from the nobility, were empowered to offer a license to practise to physicians and lawyers. These professions were therefore linked with a high social standing (Carr-Saunders & Wilson 1933). Rather than practical knowledge they underwent a 'liberal education' based on a cultured and gentlemanly ideology and style of life (Elliott 1972). They became 'learned' practitioners because of their knowledge of Latin but had little skill for their chosen profession. This distinguished them from 'common' practitioners, apothecaries, barber-surgeons and so on, who learned a skill through apprenticeship and who were thus accorded a lower place in the social division of labour (Larson 1977). In the nineteenth century elitist education and social position still went hand in hand. An alliance had developed within the university system between the landed classes and the professional classes. Careers in government, for example, were reserved for the landed gentry who had attended Oxford or Cambridge University (Larson 1977; Elliott 1972). This was how status professionalism emerged, to use Elliott's term, claiming a right to social position rather than having a particular function.

Elliott's (1972) corresponding 'occupational professionalism' arose, from the apprenticeship tradition, when occupations claimed a professional title based on the premise of a specific knowledge base and competence. Professional knowledge became a commodity, which needed to be standardised to create a marketable product. The ability of new professionals to claim competence, which was superior to the traditional status professionals, was given jurisprudence through education and certification, which superseded apprenticeship (Larson 1977). Thus, education was utilised by both status and occupational professions but in different ways, the former for social position, and the latter for competence.

The rigidity of the stratification system in the nineteenth century meant that there was no possibility of movement between the status and occupational professions (Larson 1977). Macdonald (1995) argued that the middle classes, who did not have access to the higher echelons of society, found a route to a degree of social elevation through professionalisation. Although, not necessarily connected with class mobility, these groups acted to improve their position and exploit others through strategies such as the possession of educational qualifications. The idea

that certification could be used as currency in the class structure is Weberian and the capacity to offer a general symbol of competence was of great significance (Giddens 1983). Wilding (1982) suggested that the aim of all professions was to get their training courses established in universities. If the certificate, diploma or preferably, degree was obtained from a respected establishment, more status was conferred on the occupation. The university epitomised the superiority of formal training and certified knowledge. It reinforced the authority of science and validated professionals' knowledge claims. University based education therefore became the standard symbol of authority and power: an aspiration to be followed by emergent professions (Larson 1984).

Standardisation of training and requiring students to pass difficult examinations gave reassurances to the state and the public that all those who completed a professional education would be of at least minimal competence. For this to occur it was necessary to employ Becker's second symbolic dimension of professionalism: professions should control the recruitment, training and certification of members within formal schools (Becker 1977; Freidson 1994). Becker (1977) argued that professional education tended to build curricula in ways suggested by the symbol, that is, the training had to be long in order to mystify the public that the knowledge was difficult, esoteric and required great intellect. Goffman (1969) called it 'the rhetoric of training' and it went beyond what was actually needed. There were other benefits of lengthy training for the professions. Due to the intellectual effort required of students and the time invested, the social cost of dropping out was greater (Hughes 1981), which would help to generate commitment to the profession. Wilding (1982) illuminated another effect of lengthy training: it inculcated faith and therefore confidence in the knowledge being transmitted, which helped to perpetuate professional power.

Other power strategies aimed at gaining dominance over occupational groups include usurpation and social closure: restricting jobs to people who possess a certificate. The latter was another Weberian idea, drawn on by Wilding (1982), Macdonald (1995) and others who argued that the purpose of knowledge being certified and credentialed was to impose social closure, rather than being motivated by a thirst for education. The consequence was enhanced status, security and greater remuneration (Wenger 1976). Whilst some considered this to be exclusionary, Freidson (1984) saw it both as a means to secure lifetime commitment and as due reward for the investment of time, effort and lost earnings during training. Witz (1992) thought that such 'credentialist tactics' was a further restriction to women who were excluded from the university system in the nineteenth century and were therefore reliant on other, less prestigious establishments for their education. Thus it was that Dr Casson had to borrow money to set up her own private school of occupational therapy in 1930 (Wilcock 2002) having failed to get it established in a university (Mountain 1998). Occupational therapy began as a vocational occupation, which had a relatively lowly position in the stratification system but with aspirations of improvement.

OCCUPATIONAL THERAPY TRAINING

Hugman (1991) observed that the arts and crafts origins of occupational therapy was antithetical to the emphasis required for professional development, which accounted for the increased claims to a scientific knowledge base and the move towards higher education. Following the lead of reference groups such as nursing, getting occupational therapy education into universities became an important symbol of competency. However, the historical advancement of occupational therapy education has followed a path, common to service professions (Hughes 1981; Elliott 1972). All of the early schools of occupational therapy were vocational, offering a diploma and were either hospital based or privately owned. Students could work towards a diploma to work in the psychological or physical fields or both but later a dual, national qualification was introduced (Wilcock 2002). In 1969 the typical recruit for occupational therapy was 'a middle-class girl educated at a grammar or private school, one or two subjects at 'A' level with relatives in the Health Service, attracted to occupational therapy by the scope for meeting and helping people' (Cracknell 1987). Johnson (1972) identified this as a uni-portal system of entry, the aim of which was to build a homogeneous group, inculcated with the occupational norms via a process of socialisation, which will be given further consideration later on.

Wilcock (2002) reported that the syllabus and regulations for the diploma remained relatively unchanged until the 1980s because they were set by the professional body rather than by educational institutions. The occupational therapy schools were largely organised by practitioners whose own values would have influenced the course curricula. Wilding (1982) envisaged a risk in allowing the professions to control the content of training in that there was a danger that it would reflect an idealised version of the work. That said, admissions to the training schools could be controlled, by the weeding out of unsuitable candidates, the assumption being that only professional members were competent to judge other members. Individual practitioners' benefited from this arrangement since if experts controlled admission and the training, then it was assumed the outcome would be an expert (Wilding 1982). Moore (1970) thought that the professional schools acted as the first formal gatekeepers, in setting admission standards, standards for performance in the course of training and requirements for the appropriate degree.

In 1980 'Diploma 1981' was introduced, which laid down an outline syllabus but allowed occupational therapy schools some flexibility of content. National examinations were phased out in favour of responsibility being given to the schools. The College of Occupational Therapists (COT) acted as the validating and moderating body to control standards. Responsibility for funding occupational therapy education was transferred from the Department of Health and Social Security to the Department of Education at this time (Wilcock 2002). COT's *Research and Degree Committee* and *The Way Ahead Working Party* agreed that it should implement graduate education for occupational therapists and 'urged individual schools to affiliate with institutes of higher education'

(Wilcock 2002). Writers often refer to Blom-Cooper's (1989) recommendation that occupational therapy education should be elevated to degree level (Crofts 1991; Gape & Hewin 1995) but it was not as straight forward as is usually made out. He saw pros and cons. On the one hand he thought it might deter prospective students who were practically orientated, whilst on the other, it might offer status. There was also the question of 'keeping up' with other professions such as physiotherapy. He concluded that the curricula and practical training was, at that time, of general degree standard and that there should be no change to the entry requirements. In the end he opted for the diploma to be recognised as an *ordinary* but not an Honours degree. Nevertheless, all courses now lead to an Honours degree. The case for change was based on an increase in theoretical perspectives, the need to evaluate occupational therapy knowledge on a scientific basis, and to accord members the 'cachet' of an Honours degree (Education Board 1983). In accordance with this elevation, the entry requirements have been raised (College of Occupational Therapists 2003). COT does not appear to have adopted some of the other recommendations of Blom-Cooper with quite as much enthusiasm: the implementation of a probationary period prior to full registration or the investigation of a possible merger with physiotherapy, have been largely ignored.

By 1992 all occupational therapy 'training courses' were converted to 'education' at degree level (Jay 1992), although they tended to be located in the so-called 'new' rather than 'redbrick' universities, thereby reinforcing Larson's (1977) view that a hierarchical educational system remains in place. Yerxa & Clark (1999) noted that, in the USA, occupational therapy education was placed in whichever college or school would accept the programme, leading to something of a hotchpotch. A similar situation has occurred in the UK with education being located variously in schools of health and social sciences, faculty of health, social work and education and schools of professional health studies, among others (College of Occupational Therapists 2003). Yerxa & Clark (1999) recommended that a college of social sciences would be a 'better placement in the academic community'. Recruits may now be from a wide age range, of either gender, with diverse socio-economic backgrounds and, in some cases, previous training in another occupation (a multi-portal system). There is also a part-time route which allows students to continue working whilst attending university on day release.

The recently formed Health Professions Council (HPC) has responsibility for the modernisation of education and training and the intent is to work with other stakeholders, including the Quality Assurance Agency (Health Professions Council 2002). Education is thus undergoing a further process of change. Occupational therapy writers have espoused the benefits of higher education in terms of academic credibility and equity with other professions (Stewart 1992; Wilcock 2002). However, at the time of the transition towards graduate education there were those who had concerns. Some thought that the diploma would be seen as a second rate qualification (Benson 1991; Gape & Hewin 1995), that practical skills would be lost (Kelly 1994), or that occupational therapists might train themselves out of jobs (Barnitt 1991). Others thought that the whole professionalisation process was detrimental to service delivery (Green 1991).

There seemed to be a tension between the attraction of university education with its historical and symbolic associations of high social position and power and the risk that by shedding vocational training, practical ability would be sacrificed. Now that university based occupational therapy education has been established, what have been the perceived consequences of this action? Where does the greater orientation lie: towards professionalisation associated with 'professional' education in universities with rewards of status or towards 'vocational' training where the claim to professionalism rests on the acquisition of a practical skill? They each aim for competence but the universities achieve it through abstraction and scientific theory whilst professional schools utilise concrete knowledge. The practitioners' views were explored using the following questions:

- What do you think of OT education being university based?
- Is a degree an appropriate qualification for an OT?
- When you trained, were your tutors in touch with clinical skills? Is that important do you think?
- During education, who should be responsible for weeding out OT students who are unsuitable?
- When you were a student what did you consider were the essential things to study?
- What are the tedious aspects of your work? What are the aspects that you really enjoy?

THE VIEWPOINT OF PRACTITIONERS

University Based Education

Only 22% of the group overtly stated that university based education was beneficial. Some considered that the diploma was of degree standard and it was only right that the higher certification should be accorded. Others were happy that profession specific schools had been replaced by education in its wider sense offering wide and varied experiences. A few linked it to having greater depth of knowledge. This practitioner, for example, thought that it gave occupational therapists parity with other professionals.

OT13 (community): I think you need to be able to have a good level of understanding of bones and things to be able to erm liaise... Say if you were working on the physical side with physios, with doctors and I think... I think it is very beneficial to have... you know, degree level knowledge in psychology and those sort of things.

According to Johnson's analysis of the professions, occupations used the belief that lengthy training was necessary to acquire a skill, as an authoritative symbol, which justified high economic rewards and improved status. This was despite contrary evidence suggesting that some occupations did not need to use a high level of expertise in much of their work (Johnson 1972). Barnitt (1991) recognised that status was one of the motives for moving occupational therapy into higher education. Twenty five percent of the practitioners agreed that graduate training was helpful for this reason. This quote was typical.

OT1 (physical): I don't think it can really be done any other way er in terms of it's required I feel for the status of our profession. I think... we've almost got the balance right in that we do some within a clinical area and some within university but I do feel that we need to stay university based erm to sort of maintain the professional status that we're getting.

Eleven percent of the group thought that the course had allowed them to achieve an academic level beyond their expectations, a point made in the following quote.

OT29 (physical): I thought I was going for the diploma because I really didn't think I was academically... bright enough to get a degree... Being told all the way through school [chuckle]. Erm so then I tried for the degree and I got it because it was the only option and so... I don't think it would be good to go back to the diploma now.

Some of the group however, shared a number of concerns about the academic focus of courses. For 19%, one of the problems was that it could attract the wrong sort of person into the profession. In the opinion of this practitioner, some had entered into it for the wrong reasons.

OT14 (physical): With the greater competition obviously they're looking at people whose academic level is high. Erm and that doesn't always equate to the sort of... warm, practical individual who would make your best OT. And there were one or two examples like that and there were a few people who went into it... for the degree as itself erm without thinking it's actually a vocational degree.

Education in vocational schools ensured that recruitment could be controlled, by the rejection of prospective students who did not have the required mental ability or temperament (Becker 1977). That changed with university based education: some institutions, for example, no longer conduct interviews prior for entry to the course. Barnitt & Salmond (2000) undertook research that looked at fitness for purpose of occupational and physiotherapy graduates. The results confirmed that some candidates had been selected without an interview; thereby removing the opportunity to weed out those deemed unsuitable. Although educators questioned the reliability of interviewing as a selection mechanism, one of the

recommendations of the research was the improvement of communication with stakeholders with regard to student selection.

Eight percent of practitioners were concerned about the screening procedures for applicants to enter education. Their anxiety was largely to do with ensuring that the applicant had the appropriate aptitude for the job. This respondent highlighted the importance of screening students' capacity to absorb professional values.

OT11 (mental health): I think it's a big mistake... for any course... to not interview... it's applicant irrespective of what you're doing... You need to see what you've got coming in... There has to be an interview process, which... has selection criteria, and you see the people that come through. So if university courses are not accepting people, they're accepting people without interview... they're not acting professionally in the first place, irrespective of what course they're providing... particularly however, in relation to the health professions... We're working with kids; we're working with people who are vulnerable in their disabilities, all the people in old age, people who can be exploited... Exploitation is a serious problem in this line of work and you know you have to have erm people who are going to be able to produce in the field a... degree of professionalism... you know. In other words they're not going to enter into erm relationships with the clients that's improper erm they're not going to get into financial relationships with clients which would be improper... Or anything else like that.

It has been argued that high entry qualifications for education have been used as a mystique to convince the public that the professional knowledge was difficult to acquire (Becker 1977). Many occupational therapy courses have raised the entry requirements. The risk of discrimination was highlighted by Hill (1995), who identified 21 graduates of one occupational therapy school, in 1994, who would no longer meet the entry requirements and yet they had demonstrated excellence in their careers.

Concern about the entry requirements was raised by 8% of the practitioners. On the one hand, high academic achievement was not an appropriate indicator of the aptitude necessary for the job. On the other hand, concentrating on academic ability denied an opportunity to people who had the potential to make good occupational therapists, as this practitioner explained.

OT34 (mental health): With our degree erm... students were weeded out of our degree who I thought would have been fantastic OT's... Because all of our assessments were assignment focussed... on practical things, nothing to do, although we had to pass, it didn't go towards our degree classification at all... It was all sort of assignment focussed... so people that had wonderful people skills... were wonderful practically... knew

their role... were just, when it came to the written work... maybe failed a couple of... you failed two and you were out.

Becker (1977) argued that 'education' rather than 'training' would fail to prepare students for the world in which they would have to work; a view which seems to have some confirmation in the case of occupational therapists, by the work of Adamson et al (1998) and Barnitt & Salmond (2000). The nursing profession acted as one of the reference groups for occupational therapists striving towards higher education. In the 1990s nurse education was relocated to universities and the Project 2000 proposals recommended that nursing students should spend the first 18 months of a three-year course based in the educational institute rather than on the wards. The emphasis was on education rather than training (Chapman 1998). Although the link with higher education has been considered to have benefits (Fitzpatrick et al 1993), newly trained nurses often emerged with unclear ideas about the real work of a nurse (Alavi & Cattoni 1995). There was some anxiety in the nursing profession that too much emphasis on academic attainment produced less competent nurses, which has demanded a response. Nurse education remains in universities but the courses have now been re-designed 'specifically to inculcate clinical competence' (Watson & Thompson 2000).

This cohort raised similar concerns for occupational therapists. Forty seven percent thought that graduate education did not prepare occupational therapists for the job by not teaching the skills necessary. This view was prevalent both amongst those who underwent graduate and diplomate education. The following extract is from the stance of a practitioner who had been through graduate education.

OT25 (community): Very honestly, *very honestly* it wasn't quite what I imagined. For me I certainly feel that I would struggle if I hadn't have been an OT assistant prior to my training. I didn't really feel that... the university prepared me for work... I knew what was *really* out there but I felt that it was all sort of erm... At the university it was all sort of... how it should be... in the ideal world as opposed to how it is in the real world. And often when I wrote assignments... erm initially I wrote how it was in the real world and that wasn't what they wanted to hear and they came back with poor marks... And so I eventually learned to write what they wanted to hear... And then the marks began to get better... But this isn't right, this isn't really how it is but this is what they're looking for so this is what I did to get through... but for me I just felt that it doesn't really prepare you for the real world.

This extract reflects the stance of diplomates who have had experience of working with graduates.

OT14 (physical): I think... in general... if you are doing... meeting the needs of a more academic course... then you have to achieve certain things within your training so the amount of time you spend out on

fieldwork placements is less... And so the OT who comes out... erm hasn't got quite so much fieldwork experience behind them to know what the real world is really like. And the other thing I have a bit of a problem with the... opportunities are wider and greater for different bits of fieldwork placement and a lot of the... bread and butter, bog standard, basic stuff isn't covered... They don't cover it... to a practical level... er fieldwork level within the course and I do think erm...that's...that is a bit of a problem... you know... I think they need to know what... what erm... by far the greatest majority of operational work is really like.

The practitioners considered that graduate education has provided students with an unrealistic image of the realities of work and poorly prepared them for the skills necessary. In 1933 Carr-Saunders & Wilson warned of the resistance of universities towards training in the 'technical accomplishments' required of some service professions. Training in the requisite skills would be given less credence than education.

It is interesting to note that 47% of the practitioners were concerned that academic study was prioritised at the expense of practical skills. This practitioner, for example, was at university during the transition from diploma to degree and noticed a move away from technical training.

OT17 (community): The diploma was different... There was a different structure [with the degree]. They immediately stopped the training for practice because they had to do so much more for the degree. Then we eliminated a lot of our practicals erm... you could **choose** to do splinting, you could **choose** to do this, **choose** to do that but er the majority of it was... Two thirds of it was more academic...I have to be honest and say that... I wanted to do a diploma I didn't want to do a degree...

Nineteen percent highlighted some specific problems encountered as a result of what they perceived to be inadequate training. Most of these comments were from community occupational therapists, often working in isolation, where there would be little infrastructure to address such problems through continued professional development. This practitioner considered that it was unrealistic of universities to expect students to learn all practical skills necessary for practice, on placement.

OT16 (mental health): The real nitty/gritty OT stuff they just left for you to do on placement. Which... was very much the luck of the draw as to whether you did them on placement... There were those who got to year three who'd never even seen a bath board and a bath seat... very much luck of the draw as to what you got... Most of us didn't come out as well rounded, well prepared... OT's really.

Barnitt & Salmond (2000) reported that, in the past, any gaps in skill would have been addressed in the first year of a graduate's post. However, the current work

situation demands that graduates must have the ability to work autonomously almost immediately. This raised the desirability of a probationary period after graduation. This practitioner found the training needs of junior occupational therapists could result in tension amongst other staff.

OT2 (community): We don't make the assumption that they know things when they come out. And I think... that that is different we do... almost treat them as a student when they first come out... That we're very careful on the rotations... and we make sure we put them on... a rotation that is going to be... if you like bread and butter stuff when they first come. ...Erm...I think on a personal point of view... you can find it incredibly annoying... that you're basically... paying a member of staff who can't do what an assistant can do.

This respondent found that it was difficult to check experience.

OT31 (community): The difficulty once people get working, if you've worked for twelve months in a place like this you're assumed to be experienced... Nobody checks that, there's no measure by which we say right by this stage you should know how to do this, this and this, how are we going to measure that...? It's just on-going it's just look at what people are doing and... hoping that there aren't any gaps.

The government has proposed to replace the Whitley pay and conditions systems for NHS workers. The scheme proposed in *Agenda for Change* (Department of Health 2003) provides a national framework covering pay and conditions for most staff in the health service and is underpinned by an NHS-specific job evaluation scheme. One of the strands to the scheme is career development based on a Knowledge Skills Framework, which is an outcomes based competency framework linked to development review (UNISON 2004). It has also introduced the concept of a 12-month period of preceptorship for new entrants to assist their progress through the required standards of practice. This to all intents and purposes is a probationary system. It should provide the measurements requested by the last respondent and suggests that Atkinson & Steward (1997) were right to argue that university education prepares graduates for lifelong learning but not so well for what they actually do.

In summary, those practitioners who thought university education had been helpful to the profession cited parity of status with other health professions as the main benefit. Others had concerns that it attracted the wrong people to the profession, which is something that it can ill afford to do. Newman (2001) acknowledged that, since all professions allied to medicine are now graduate entry, some would inevitably use their degree as a springboard to a more lucrative career outside the NHS. This has implications for retention of staff at a time of great difficulty (Sutton & Griffin 2000). The national vacancy rate for occupational therapists was 4.9% in 2002 (Department of Health 2002), which is a significant figure for a small profession. Lack of status and pay were among the

issues that have influenced withdrawal from practice (Rugg 1999; Sutton & Griffin 2000). The inference from the practitioners was that 'professional' education had attracted less caring practitioners, without the necessary interpersonal skills, who were more interested in their own advancement. The screening procedures left little opportunity to weed out unsuitable candidates, whilst the high entry requirements were misleading for a profession where personality is as much a part of the job as technical skill. Graduates were not taught technical knowledge and there was a false expectation by universities that all practical skills would be learned on fieldwork placements. All of this created tension in the workplace with senior staff having to cope with juniors who did not know what to do. So did the practitioners consider a degree to be an appropriate base qualification?

The Appropriateness of University Education

Freidson (1984) argued that some form of accreditation and occupational title was necessary as a way of identifying 'experts' but the appropriateness of particular forms of credential, for the type of knowledge claimed, was open to debate.

Twenty five percent of the practitioners thought that a degree was an appropriate qualification for occupational therapy. This respondent linked it to research.

OT1 (physical): The diploma didn't do the full research project and the degree did emphasise more... research. So I take that as being the main difference then definitely yes because we have a... quite a poor evidence base.

Seventeen percent thought that graduate education was the inevitable result of following the trend of other reference groups. The diploma has now been devalued in the opinion of this practitioner.

OT27 (mental health): I think OT needs that standing. A lot of other professions are degree based and I think to have that... We need that acknowledgement that the training you've done is a good training and a degree does that whereas in the past a diploma was acceptable... I don't think it has that kind of standing any more.

Eleven percent of the group thought that a degree was appropriate for reasons of status, again as far as another practitioner was concerned, because a diploma carried little kudos.

OT28 (community): I sometimes think and this shouldn't be the case... that it maybe helps OT's to be recognised as professionals by having a degree... rather than having a diploma. Erm... and I don't know... it seems wrong really because it's like people's perceptions... If you've got a degree... yes she can be a professional and you have to be clever but if you've got a diploma then you're probably not.

Thirty percent took the view that, whilst they supported the idea in principle, they had reservations about a degree being the base qualification. The greater proportion was from the physical sector and their concerns were largely centred on the premise that practical orientation was sacrificed in university based education. The following quote was characteristic of this view.

OT23 (physical): I think you do need to be... have some of the academic side. You need to learn the anatomy, the physiology, then the OT side. You need to know about the OT skills... most of them but it's silly things like the frameworks... The terms of reference and all those type of things... You don't need to know those as in depth as your anatomy and physiology and erm all the other side of it... So I think it needs to be a degree course erm but it also needs to have the practical element to it as well... that's what OT's all about.

This practitioner was concerned that there was such wide variation in course content between universities that it produced differing competency levels.

OT29 (physical): Certain universities don't do half the amount of erm physiology that we did and er... Supervising [students] now it's really obvious... they just don't know it, they just don't teach it... And I just think... and we're all coming out with the same qualification at the end of the day?

In contrast, 17% were of the opinion that degree based education was not appropriate for occupational therapists, a point made in the following quote.

OT15 (physical) I'm not quite sure whether the actual basics of training for an ordinary basic grade OT necessarily needs to be at degree level... Or maybe they need a... look at what they... Look at how they're actually training... and justify it... having seen how some of the basic grades come out I just think 'God have they got a degree?' ... How did they manage that?

Overall, 83% agreed that it was appropriate for occupational therapy education to be university based, partly because a diploma has less public standing. But many had reservations because practical skills were sacrificed and there was too much variation in competence. Some thought that the initiative was driven by the trends of other reference groups or for reasons of status. It is a small percentage but, nevertheless, there were some occupational therapists who thought that graduate education was not good for the profession. In their opinion, the fact that other health professionals have taken that path was not considered a good enough reason for occupational therapists to have done the same.

Knowledge and Theory Development

Ryan (2001) considered occupational therapy education to be 'fractured'; one of the effects of which was that academically produced theory was not valued in clinical settings. Creek & Ormston (1996) and Higgs & Titchen (2001) argued that occupational therapy educators were losing touch with practice in their pursuit of an academic profile. Eraut (1985) suggested that universities and practicing professionals needed to assume joint responsibility for knowledge creation, development and dissemination. For this to occur each needs to be aware of the other's situation. To find out whether or not this was the case the practitioners were asked about the importance or otherwise, of educators being in touch with clinical skills. Opinion was divided. Thirty three percent considered that, during their own education, their tutors were clinically competent. This quote was typical.

OT10 (community): Most of them I think carried a small caseload or were still practicing which I... I thought was excellent because I think it's very easy to... lock yourself into academia world and lose contact with you know what's going on in the clinical world.

Thirty six percent considered that *some* tutors were in touch, as this practitioner explained.

OT23 (physical) Some were, some weren't, we had er, when I was there we had a... maybe two or three new members of staff started, all of them fairly young, and all of them practicing quite recently. Whereas the course leaders... er had been out of practice... for so long that I don't think they really knew what was happening... everything was very idealistic.

The following quote reflects the 30% who thought that their tutors were *not* in touch with clinical skills.

OT26 (mental health): I think there was a real recognition that people weren't... up to date so it set the agenda to make the students go out and make more of their placements.

Thirty three percent highlighted the reasons why it was important for tutors to be up to date in clinical matters. Their observations revealed a perception that practitioners, constantly adjusting to changes in the workplace, drove practice. There was scant sense that educators were in the forefront of appropriate theoretical advancement, a view expressed in this quote.

OT30 (mental health): Theory's important but it's got to be applicable theory and it's got to be practical theory and... you know the kinds of expectations that some of the lecturers had of us... We thought 'have you really worked in a hospital where you've got fifty odd patients that you've

got to deal with?' ... That kind of thing, so I think it's important from that point of view and also for keeping current... because I think theory changes and I think theory's informed by practice as much as practice is informed by theory.

The practitioners considered that it was important for educators to maintain links with practice to ensure that their work was grounded in reality. There was strong agreement that universities and practitioners needed to collaborate in new knowledge and theory development. Those tutors who did not keep up to date with clinical skills were not reflecting the needs of practicing occupational therapists. There was a sense that practitioners were driving the profession forward and that some educators failed to respond by being out of touch with practice; the result being that the value of theory suffered.

Weeding Out Unsuitable Students

According to the symbol of profession, when education is organised by practitioners, entry to it can be controlled from the perspective of members, by weeding out unsuitable candidates. The lengthy training could also be used as a salvage mechanism to eliminate any students who had been mistakenly accepted on to the course (Becker 1977). The assumption was that only professional members were competent to judge other members (Wilding 1982). This control has now been transferred to the academic institutions. What influence if any, has this had on current occupational therapy students? Occupational therapy education is composed of time spent in university and practical experience in clinical settings (fieldwork), where fieldwork educators supervise them. Students are required to pass both the academic and clinical aspects. The practitioners were asked where the responsibility lay for weeding out unsuitable occupational therapy students.

Nineteen percent of the group thought that fieldwork educators, who are practitioners, should primarily be responsible for weeding out unsuitable students. The reasoning behind this view is explained in the following quote.

OT9 (physical): The only way you really see it is in work settings... because I mean somebody can be... really a wonderful academic but if they've not got the skills to communicate or... whatever... then... you know... I mean they can have four straight 'A's and not be able to talk to someone and you wouldn't see it in the university setting.

Fourteen percent, including this practitioner, thought it should be the university educators.

OT4 (physical): Well I think the college have got the biggest responsibility... and I think it should start at the erm the interview process when the... student goes for their interview for the college.

Sixty seven percent considered that it was a joint responsibility between the fieldwork and university educators. This characteristic view was expressed in the following quote.

OT35 (mental health): Through the training I think it should be through the product of liaison and negotiation between the formal school educators, university educators and the formal practitioners or supervisors out in the field. And if there are concerns either way... it's important that both... take the responsibility of failing the student rather than passing a student because it's somebody else's responsibility.

Forty seven percent recognised that some practitioners found it difficult or were reluctant to fail unsuitable students. Most blamed supervisors' lack of training or avoidance of an unpleasant event, as revealed in the following quotes.

OT13 (community): The trouble is it's quite hard because... er... I mean from what I can hear and people are even going on placements now that the actual supervisor hasn't done a fieldwork educators' course.

OT8 (physical): I've been on one of the failure student courses... after I'd actually failed a student anyway but... I was the only one that had done that and everybody said 'aren't you brave I couldn't do that' and I thought how silly... could have shook them.

This was consistent with Illott's (1993) work, which found that 64% of trained fieldwork educators ranked 'failing a student' as their first or second most problematical responsibility.

Among the practitioners, 17% were concerned that universities were reluctant to fail students, as this practitioner reported.

OT2 (community): I don't like the fact that it's basically down to the fieldwork educator that you are the last ditch person and they [the universities] actually tell you, you're basically the only people that can actually fail somebody.

Illott (1993) confirmed that occupational therapy schools are penalised financially, if too many students are failed, which is therefore a mediating factor for academic staff.

Fourteen percent thought that the scarcity of occupational therapists sometimes influenced the decision, as this practitioner explained.

OT2 (community): We're desperate to get people into the profession, how many of these students can we fail?

Seventeen percent had concerns about the impression this conveyed. This comment was typical.

OT28 (community): It's not a good reflection on the profession, I think we should be a lot harder... at failing people.

Illott (1993) agreed, concluding that there were positive outcomes of failing unsuitable students, in terms of the student, the school and the profession. She recommended that institutional pressures must not be allowed to 'jeopardise the quality of the outcome – a safe, competent occupational therapist'.

Yet, 28% had personal experience of unsuitable people qualifying, the consequences being explained in the following quote.

OT10 (community): I had someone on my course... who was *clearly* unsuitable at that time in their life and she was very academically gifted. She cruised through the academic side, she scraped through the fieldwork, she did graduate, she did qualify erm and her first post ended up in her being sacked. And I just think that shouldn't have happened because it should have been stopped... in the first year actually. It was so glaringly obvious at that time she wasn't suitable so... I guess there's a chain and at some point I would hope at some point that someone is going to say no and with *this* person it ended up with as soon as she then qualified... she couldn't maintain her post and had to be stopped.

The majority of practitioners considered failing students to be a joint responsibility, between fieldwork and university educators. They agreed with the idea that it required an occupational therapist to judge another but nearly half accepted that practitioners found it difficult to fail students. Some were concerned that university educators were also reluctant to fail students. The consequence was that a relatively high proportion of the group had personal experience of unsuitable people being allowed to qualify. There was a belief that occupational therapists *should* be effective gatekeepers to the profession by removing unsuitable candidates. Not doing so, portrayed a poor professional image but the elimination of poor students was not carried out adequately. This was attributed either to a perceived weakness on the behalf of fieldwork educators or because of imposed restraints on university educators.

The Essential Things to Study

Larson (1977) argued that alignment to science would have the effect of making 'theoretical' and 'practical' knowledge distinct. Creek & Ormston (1996) suggested that this has been the consequence of occupational therapy education being transferred to universities. Bennett & Hokenstad, as far back as 1973, maintained that training should stress the methodologies of applying skills and there should be less emphasis on cognitive knowledge. Haug (1973) and Reiff (1971) suggested that there was a part of professional work that was more 'art'

than science. Such knowledge cannot be codified or transmitted academically but is no less important for that. This was an idea explored by Eraut (1985) when he challenged traditional assumptions about how and where professional knowledge was acquired. Professional education tended to concentrate on technical knowledge that could be codified and passed on systematically through writing, whereas practical knowledge was assumed to be idiosyncratic and developed on-the-job. However, Eraut argued that it was possible and desirable to intertwine theoretical and practical knowledge and to create written knowledge relevant to practical skill. Practitioners use generalisations and practical principles in the application of their work. The knowledge brought to each case comes from 'semi-conscious patterning of previous experience' but such generalised principles are hard to articulate and thus he encouraged research that would explore, codify and develop practical knowledge. The practitioners were asked to recall the essential things to study during their own occupational therapy education in order to understand their stance on theory and practice.

Sixty seven percent thought that it was most important to study concrete theory during education: subjects such as anatomy, physiology and psychology, which could easily be linked to conditions likely to be encountered in practice. This was the case even for mental health occupational therapists: the least likely group to use concrete theory in the course of their work. The following quote was characteristic of this common view.

OT24 (community): The anatomy and physiology... that was the big thing really er...(2)... a lot about the clinical work and the er... I didn't think the theoretical side of it... the models and approaches, at the time I didn't... didn't mean a lot to me no... even when I had placements and I was meant to relate it, it didn't mean a lot.

Twenty five percent specified that the application of patient handling skills was important. Fieldwork placements were particularly useful for this and many other practitioners.

OT4 (physical): Once you get on placement it sort of fits together then but I think, yeah there should be more time spent on placement than in college perhaps sometimes... I think that's where you learn most of your skills.

Allied to this, 8% thought the teaching of practical skills whilst in university should be given greater precedence, a point made in this quote.

OT24 (community): Going back to my training... we didn't do a lot of practical OT that's why I did it on the placements... like the real... To be able to use pieces of equipment and know what equipment... you know, just the basics of OT and actually assessing somebody. I didn't do a lot of that at college and I think it could perhaps be a little bit more practical, we've gone very much more theoretical really.

Eight percent contrasted this with the observation that the emphasis at university was on abstract theory, which, as far as this practitioner was concerned, was not used in practice.

OT21 (community): I think when you're a student it's drummed into you about the models and approaches and things like that. So we all used to panic over those and everyone struggled but... frames of references, can't even remember them now...

The practitioners supported the rationalist view of education where a sound knowledge system, pertinent to current practice, would be transmitted from teacher to learner with the aim of producing competency (Purdy 1994). They expected to acquire concrete knowledge, which could be used as a base to learn how to develop and apply practical skills. But making education more academic has meant that practical skills were given insufficient credence and graduates were ill prepared for the workplace. When this is considered in conjunction with their opinion that practice should drive theory, the recommendations of Jenkins & Brotherton (1995a) and Higgs & Titchen (2001) would be well received by this group. Clearly influenced by Eraut, they considered that the separation of theoretical and practical knowledge in occupational therapy education was erroneous, which drove them to present their own models of learning-in-practice. Each argued that knowledge, inductively derived from practice, would better prepare students for the workplace.

Tedious Aspects of Occupational Therapy

Wilding (1982) argued that lengthy training would result in people becoming over trained for their job, the result being that practitioners would consider much of their work to be tedious leading to a decline in the standard of service. There are indications that this might be the case for some occupational therapists (Barnitt 1991). The practitioners were asked what they thought were the tedious and enjoyable aspects of their work.

Seventy eight percent described paper work and administrative tasks as being the most tedious aspect of the work routine. The following quote was typical.

OT27 (mental health): Administration... statistics, written work erm lot of writing, report writing, those kind of things.

Twenty five percent found some aspects of patient work tedious. For example, balancing patients' wants against their clinical needs and budgetary restrictions could be tiresome for this community occupational therapist.

OT32 (community): Arguing with clients... explaining to clients why they can't have things... explaining to clients that we've got a limited budget and we have to target that money.

This mental health occupational therapist, with lengthy experience, could find patients with enduring mental health problems tedious.

OT11 (mental health): I'm probably getting to the stage now where I'm mostly working with long term psychiatry and the idea that it's all the same process. And eventually the stone in the stone garden will change if you persist in looking at it every day and watching the bits of rock fall off and the moss growing and so forth... is kind of wearing a bit thin now... You know some of my clients haven't moved for years and they're not going to move.

This physical occupational therapist found routine orthopaedic ward work tedious.

OT23 (physical): The very basic OT... things like a toilet assessment, bathing assessment, I think... I'll get... well I'll ask our Technical Instructor to do it instead for me.

Although there is a risk that academic training could lead to practitioners becoming bored with their work this does not seem to be the case for this group. The tedious aspects of occupational therapy revolved around paperwork and shortages, both of time and resources. Whilst there were a few aspects of patient work which were considered tedious, the vast majority of occupational therapists enjoyed working with patients. Despite perceived failings in the education process they retained a sense of vocation in their duties. They had not become cynical or over-trained to the extent that they found the work dull and for them, it had intrinsic value.

Enjoyable Aspects of Occupational Therapy

Virtually the entire group considered that patient contact was the most enjoyable aspect of occupational therapists' work. The following quotes demonstrate this widespread view.

OT21 (community): Well I love to stay in contact with the patients, patient involvement, I love it... I love getting in the car and driving out to someone's home... you know I love that.

OT18 (mental health): Well being part of the process that enables patients to... get better basically... to function, you know at a higher level. To feel more confident about themselves... to actually develop insight... all those ways that patients develop independence and confidence and believing in themselves and all the rest of it.

OT22 (physical): Telling old ladies they can go home... yeah I mean it's basically I enjoy being able to help somebody and making sure that they can go home.

In summary, university based education was considered an appropriate base line qualification for reasons of status but it did not truthfully symbolise competency. Inappropriate candidates are allowed into education and once they have been accepted it is difficult to remove them. High entry requirements may deny access to people who have the potential to make good occupational therapists. The practitioners considered that the education process has made theoretical and practical knowledge separate. The requirement to appear academic has been at the expense of practical skills, which has resulted in irrelevant theory being taught and the newly qualified finding that they are ill equipped to cope in the work place. Thus, in the opinion of this group, the control of training into professional practice has been weakened. The long term effects on status, in the light of these findings, remains to be seen. Despite this, they were a practice-orientated group of occupational therapists. They enjoyed providing a service for patients and the tedious aspects related to those that distracted them from carrying out the real work of helping people.

Attention was then directed to the views of the College of Occupational Therapists (COT).

THE VIEWPOINT OF the COLLEGE of OCCUPATIONAL THERAPISTS

University Based Education

Two respondents suggested that there had not been much clarity of thought when the decision was being made regarding university education other than the need to follow reference groups. As this respondent explained,

COT2: It was just something that evolved along side the erm... the degree status of a number of other professions and also more latterly the turning of what were polytechnics into universities.

One respondent thought that the diploma was equivalent to degree status education.

COT4: If somebody was a... diplomate... erm ... (2) ... I don't personally think... that there's a huge... differential, it's swings and roundabouts. I think there's... people that qualified with a diploma... actually... achieved a qualification that was at a degree... level erm I think that was very obvious at the point that the change was made.

Three COT respondents considered that university based education was beneficial for reasons of academic credibility. This view was expressed in the following quote.

COT7: I think the introduction of degree level education has been... a tremendous thing because also... What has to be there... is educational rigour not just with professional concerns but it has to be educationally sound and I think they are educationally sound.

Three thought that the status of the profession has been raised, although this respondent considered that, if status was the aim, higher education has only been partially successful because it has tended to be situated in low status locations.

COT1: If the... benefits in terms of perceived... status... are there... Being able to say we're a fully graduate... profession... I think the downside of status is that most courses are not based in high status universities. They're based in poly's and therefore if you look at things like research assessment exercise the future of the profession making the most of the university sector to promote the theory base of the profession... we're not well placed.

Concern about the exclusionary effect of high entry requirements, was noted by two respondents, as this one explained.

COT6: It means that certain sorts of people aren't coming through into the profession and therefore don't have the kind of insights and... I suppose

the best example of that is ethnic minorities... where the situation if anything is getting worse. I can't necessarily put that down to the fact that education now goes on in universities but there's broader evidence which says the harder the qualification to get in... Certain groups of people get excluded too far down the line... So... broadly I think it's very positive but I think there are some areas of concern.

Entry requirements are high in an attempt to suggest that occupational therapy is difficult to learn but as this respondent reported, this can deter prospective candidates and there has, in fact, been a decrease in applicants.

COT5: People will want to try and push up the academia to such a level that erm ... that people say 'oh we've got to make sure that we look really erm attractive and very sort of erm academic so therefore we'll make very... very high academic requirements'. And recently there's been a slight... there's been a decrease in applications because people or careers advisors are saying 'oh no it's a harder option, look at nursing or something' so it does... it does actually have an impact on us as well I think as a profession.

As far as these COT representatives were concerned, university based education has increased the academic credibility and status of occupational therapy but at the expense of excluding some who might have been an asset.

Control of Occupational Therapy Course Content

Johnson (1972) commented that once training courses were established in universities, staffed, in part, by non-members of the occupation, the academic institutions would have the power over training, at the expense of the practising membership. Wilding (1982) also cautioned that professional training in universities tended to develop along the lines that non-practising members of the profession dictated rather than what society needed. What was the case for occupational therapy?

Most agreed that professional members controlled the occupational therapy curriculum. This respondent explained the process.

COT4: The curriculum framework is the responsibility jointly between the... College of Occupational Therapists and currently, the OT Board at the Council for Professions Supplementary to Medicine. And that responsibility is exercised through the Joint Validation Committee the JVC. That curriculum framework... then forms... part of the standards that courses have to meet in order to be validated and then re-validated over... periods of time... so erm... the... control at that level is very strong.

However, one respondent was critical of the way that COT had absolved some of the responsibility for curriculum development.

COT7: I feel that the way Council works at the moment is very much concerned with the running of COT and has become less and less concerned with the practice of occupational therapy. So things like the new curriculum framework have been delegated down to a small group and Council members who are the ruling body have never seen it and have actually chosen not to see it so I'm sort of really concerned.

Two respondents considered that the flexibility given to universities in designing course content, without central control, had a downside, a point made in the following quote.

COT2: The standards I... see are very variable... erm ... across the colleges the reputations that the different colleges have got in house are very variable.

This respondent recognised that it was difficult to evict a poor student from universities.

COT1: Many universities are lenient towards... and wish to retain students... And if students appeal against a decision then most academics feel that the university's working in the favour of the student... because they don't quite understand... studied the statutory regulations, the professional conduct... that aspect of the responsibility.

Two respondents expressed concern that universities had too much power with regard to curriculum content. In this extract examples were given of the ways in which this could be countered.

COT7: I think a strong head of school... can argue... their case for what they want to see in their programme and they gain respect for doing that... Weak heads of schools... I suspect that the university... or the college has the strongest lever for the course... I think JVC has got... a very strong hold but I think... in order to maintain that... the professional body needs to be acutely aware... that it needs rigorous standards. And it can't just put things forward that are like log wood and apple pie that we've got to make recommendations which universities can... can relate to. And the QAA [Quality Assurance Agency] can relate to and make sure that we're still getting in there... what we as occupational therapists want to see.

There was a general understanding that occupational therapists controlled the content of curricula but there was underlying disquiet that COT was not providing influence at a high enough level and that universities were exerting the greater power.

Knowledge and Theory Development

Two respondents thought that graduate education produced competent practitioners but they had reservations. Here, the division between practice and education was raised.

COT7: I think we're turning out people... with a very sound academic background... and I think we're also turning out some really good practitioners... What worries me about what's happening with education is that there is... becoming to be a big divide between education and practice.

Later, the same respondent raised a concern that some educators were too removed from practice.

COT7: Maybe... the university education has moved too far from practice and maybe some of the people... in education have moved too far from practice themselves and haven't got a commitment to staying in practice... I know there are people who are absolutely committed but I also know people who say 'well I was bored with clinical OT so I thought I'd come into education'... Well, you know, we don't need those people in practice you don't need them in education either.

Three thought that theory should be derived from practice, with recognition that too much emphasis on academia could threaten other skills. In this respondent's opinion, the professional project could be counter-productive.

COT6: Because OT's not just about academic qualifications it's a practical... based profession it's a profession that's based on... caring for people in one way or another and er... I'm not sure that a professional profile is wholly suited for treating the whole patient profile... as it stands.

Some representatives of COT then, considered that the decision to move into higher education was made on the basis of following a trend set by others rather than any serious deliberation as to the implications on practice. There was an eye to improved academic credibility and status; aims which were regarded as having been achieved, albeit with a slight tarnish as a result of courses being situated in the new rather than 'red brick' universities. Concerns about high entry requirements being exclusionary or deterring prospective candidates were aired, the consequence being a decrease in applicants. It was acknowledged that a division between practice and education existed and some educators were regarded as being too far removed from practice. There was agreement that theory should be derived from practice, in collaboration with the universities, if the challenge to practical skills and the caring nature of the work, was to be countered. Most COT representatives thought that course content was professionally controlled and that the newly qualified were able practitioners but

variations in the standard of education between universities was noted. One respondent thought that COT should be more involved in the development of the curriculum framework at a higher level. Some regarded the universities as having significant power over occupational therapy education but there were ways in which this could be resisted.

How did this compare with the educators' perceptions?

THE VIEWPOINT OF EDUCATORS

University Based Education

There was acceptance that university based education was an inevitable trend but two educators linked the benefits to improved status. According to this respondent, it made it an attractive profession.

T3: I think the plusses of moving... from a diploma to a...(1)... a degree... are really twofold... One is obviously...(1)... the attraction and the standing of the profession as there are more and more degrees... The thought... processes... are now required... of an occupational therapist... to work in practice... are degree level... so I think by bringing it into that by... the way teaching occurs... by the students... uhm... skill... in em... Particularly modular programmes... where a lot of the work is investigative... and analytical...(1)... has moved... forward...(1)... those processes... I think it's... moved it forward in attracting people... in a way... to come in.

Two respondents' thought that academic credibility has been enhanced through university education, a view expressed in this quote.

T2: I think there is the... em... there is the academic rigour that you get within a university... em the large addition of... and understanding of research.

This respondent saw a number of benefits to university education in terms of mixing with students from other health disciplines and access to better computer and library facilities. However, the promised rise in status has not occurred.

T1: There's no greater status... em... there are no... really research opportunities... em research funding is still controlled by the old universities in this area... em and the new universities were very much cut out of that loop when the Department of Health was skimming money for health research.

Despite the benefits this respondent recognised that there was a risk of attracting the wrong sort of person into the profession because,

T3: ... people see it as a means to get a degree... who are not necessarily... the people you may want to have as occupational therapists... because it is a cheaper way... to gain a degree... qualification... in terms of finance.

Conversely, a university base may deter people with potential.

T3: It may have put some... mature students... off... who feel... they can't possibly go to university... although university is widening its... doors.

All agreed that there was resistance to interview prospective students, a point made in the following quote.

T1: The university doesn't like us to... interview... students on a one to one though because [it's] quite time consuming.

They believed it was important to continue to do so but, whilst in the past only those considered the cream of applicants would have been selected, this is no longer the case. This educator cited economic reasons.

T2: We now no longer do that... er we can't afford to do it... em we take people who... who are sound... that we no longer can really... really em... look for the very, very best.

Overall, there was a mixed view about university education. It had benefits in terms of status and academic credibility but there were reservations that the ability to control entry into education was restricted.

Control of Occupational Therapy Course Content

When asked how much influence occupational therapists had on course content, one educator thought that there was strong professional control.

T2: I'm glad to be able to say that... I... I think the profession has... huge [background] control.

However, since the move to universities the profession does not solely supervise education. Occupational therapy education is professionally monitored by the Joint Validation Committee, which is organised between the Health Professions Council, the College of Occupational Therapists and the university. University monitoring also occurs through the Quality Assurance Agency for Higher Education, which produces a benchmark statement establishing standards of proficiency (Carman 2000). Education is thus heavily regulated, as this educator reported.

T3: The ...(1)... other domain ... that's come into this [laughter]... is the Quality Assurance Agency... and the Bench Marking Standards... so... em... for the next validation there may even be five... people... who are saying... what we must have... in an occupational therapy programme.

According to the same educator this can create conflicts of interest.

T3: ... it's fine when they all agree...(1)... but... I think... each has... their own...(1)... agendas... of what ought to be in... and we still only have three years to fit it in.

Two respondents noted that occupational therapy courses must fit in with university business plans, as the following quote explains.

T1: The aim of this university is to say 'this this and this'... and so when we... are setting up our courses... we have to look at what the universities... em... aims and objectives and business plans are...

Timetables were also an issue as there was pressure to reduce practical skill tuition. For this educator, those courses with a strong practical element,

T3: ... do not easily fit... into some of the university... schedules and timetables... where a lot of courses... have a full year out...(2)... so some of the dynamics... I think... are problematic...(3)... but... they can be overcome.

Three respondents highlighted a lack of freedom in choice of teaching methods, as this educator reported.

T1: In terms of... the staff I think... there have been... less benefits... for us... um... in terms of things like less freedom to teach what we want to teach when we want to teach it, how we want to teach it.

For example,

T1: We're... being instructed to teach in particular ways... um... we're being told we can't have as much contact with students... you know. We have to cut our hours down... but we have student contact... we're... We're told how many students we must have in particular groups so they don't like small group teaching which... of course is very important for OT in particular... so we had some real battles to try and keep that.

Two respondents acknowledged the pressure from the universities to increase student numbers, a point made in this quote.

T1: With falling student numbers... and... falling numbers of applications... it's bums on seats... so to say... em because it's about money... If you don't fill our number of allocated places then we lose staff posts... and the university loses money.

Two respondents agreed that this has made the process of failing a student from

an academic perspective quite arduous. As this educator explained, this has led to a tendency to rely on fieldwork educators.

T1: I think this is where the fieldwork is really important as well... em because I think that weeds out people who... maybe... I mean we've had students... who've been very good academically... and hopeless on placement... you know... I mean incompetent unsafe... and they've gone... you know... and we've had a battle... as to why they should go.

This educator acknowledged the inevitability that some people have qualified at an incompetent level.

T2: People go through to the profession who shouldn't... and that is very...(1)... very worrying...(3)... very worrying... from a professions point of view but importantly from a clients point of view.

However, there were ways in which educators were able to resist some of these pressures. This respondent demonstrated how practical skills training has been retained, for example.

T3: I think because we've been here long here long enough... and we're big enough... we withstand them...[pressures] em...(1)... yes... Because obviously practical subjects are... expensive... to resource...(1)... When you have a woodwork room... when you have a kitchen... cookery... you know... the equipment to do that... and...(1)... and obviously practical subjects... for health and safety reasons... are running small groups...(1)... So again...(1)... expensive in staff time...(2)... however...(1)... that does not prohibit us from doing it... and we have retained...(1)... uhm... practical work... within... many of the modules.

The capacity to fail a student was strengthened in this example given by the same respondent.

T3: A student is not allowed more than one fieldwork failure...(1)... So where a student can redeem an academic module... at any stage... through the course...(2)... part of the regulation on this programme is... they are not allowed more than one failure in fieldwork.

Although one respondent thought that the control of course content was in occupational therapists' hands, education is heavily regulated by other agencies. Educators are subject to a number of pressures: to fit in with university business plans, to limit practical skills training, to submit to specific teaching methods. They are required to keep students numbers up and not be too selective; one of the effects of which has been that incompetent people have been allowed to qualify.

Knowledge and Theory Development

There was some disparity of thought regarding the origins of occupational therapy knowledge creation. This respondent advocated the integration of theory with practice and considered occupational therapy to have brought this dimension into university education.

T2: I think... we amongst other professionals and other groups have... have actually improved university education... by bringing into it... this link between theory and practice.

This respondent saw a division between theory and practice and blamed practitioners for failing to keep up to date.

T4: I did... perhaps...(2)... think... students are stuffed full of theory at university... and they go out in placement... and they're stuffed full of practice...(1)... And in some magic way... the two come together...(2)... uhm...(1)... and having worked in both areas... I think it... the difficulty falls... more with clinicians... who... don't... keep up to date with theory... than it... does...(2)... with lecturers... at university... who don't keep up with practice.

On the other hand, this educator sensed that theory was not leading to good practice, nor was it serving the best interests of patients. Others (the State) were dictating what form the work should take. This reinforced the need for knowledge creation to arise from collaboration between practitioners and academia.

T1: You know instead of kind of being true to ourselves and forging a path... I think we've... we've been kind of... like reeds bending in the wind in order to try and pick up the latest...(2)... em...(1)... you know, priority... Somebody else's priority instead of saying 'OK what's a priority for us and our clients?' ... Let's forge ahead ...(1)... em ...(1)... I mean do we really want to do discharge assessments? Is that really what OT's should be doing? Do we really want to give out bath equipment and things like that in social services?

Most educators then, agreed that university based education has benefited status and academic credibility, although for one respondent this was tempered by poor resource availability, relative to those that the old universities could attract. Educators too, had concerns about high entry requirements being exclusionary. They believed that there was professional control of course content although validation from the Joint Validation Committee, Health professions Council, College of Occupational Therapists, Quality Assurance Agency and Bench Marking Standards, introduced inconsistency of opinion as to what should be included. In addition, courses were organised around university semestration and there were acknowledged restrictions on what to teach and how. Business

considerations meant that there was a reluctance to expel students, with the result that supervisors in clinical settings were given the greater onus to fail them. No system is perfect but incompetent people have been allowed to graduate and in this sense occupational therapy educators have not acted as effective gatekeepers to the profession. However, there were a number of ways, in which they have responded, for example, presenting a strong case for the teaching of practical skills to continue. The pressure to abandon interviewing of candidates prior to admission to the school could be withstood, although there was a necessity to accept people who would not have been successful previously. In another example, one institution has established the principle that students should not be allowed more than one failure in fieldwork. Strong leadership was the key factor. There was general agreement that practice and theory should be integrated but there was a lack of accord regarding whether knowledge creation originated in the clinical or academic arena and a suspicion that theories had been adopted because they were fashionable rather than relevant to practice.

Finally, what did the three members from the Council for Professions Supplementary to Medicine (CPSM) think?

THE VIEWPOINT OF the COUNCIL for the PROFESSIONS SUPPLEMENTARY to MEDICINE

University Based Education

All of the respondents regarded the move to higher education as inevitable, although the concern that practical skills may be lost was aired in the following quote.

CPSM1: I know... some of the professions were very sceptical about the value of moving to higher education because they saw it as being... erm. The risk being that they'd be exposed to the culture of purely academic abstract research and all that mattered was the number of refereed publications... Whether patients got better would be lost sight of.

This respondent regarded the business ethos to be a potential threat to occupational therapy.

CPSM2: I have some views about...(3)... some of the ways that individual universities are trying to influence education... today...erm... Universities are organisations...erm... have to make money and I don't think it matters to an awful lot of them... to the individual university... It doesn't really matter to them how they get that money in and I think... that if we didn't have the constraints of the validation process and the... the regulating body and the professional body... part of that validating process, that there would be... There would be things happening in the education of health professionals, in occupational therapists, which we, as professionals wouldn't be happy about. I think they would try to push the educational development in a way, which is not healthy for the profession as a whole.

In particular, the pressure to introduce Masters level entry was a sign that the profession is less able to control entry to training, which was viewed as problematic for this respondent.

CPSM2: At the moment there's the beginnings of quite a lot of debate about... Masters level entry... now the universities see this being... a cache for them to have more Masters level programmes erm... and of course it probably brings them in more money ... but ... I and many others amongst the profession are very wary about moving in that direction. Occupational therapy is still and should be very much... a practical... profession... We need sensible down to earth practitioners as well as people who can do the research... and... I think that... the amount of time that would be involved in getting the Masters, doing the Masters dissertation and everything would be at the expense of an awful lot of practical skills. Which occupational therapists need in order to be occupational therapists and I think... well a lot of us feel that at the

moment it would not do the profession any good. I think... we would lose credibility and... we could be laughed at... So there are some people in the profession who are pushing for it but there's an awful lot of us who are saying whoa, steady, let's think about this a lot more carefully and don't let the universities... push us into something which we're not sure we need.

Control of Occupational Therapy Course Content

Two of the respondents considered that the universities, rather than professional members, had strong control over health care education.

CPSM3: Well they have an awful lot of control... They want to present the degree... it's their degree... it's not the Boards and it's not the Colleges... The actual degree belongs to the university... is produced by the university it is a university degree ...so... they... they are the ones who actually... control it, it's theirs... it's their property in a sense.

The CPSM members considered that, once healthcare education was removed from the NHS and other allied professions adopted graduate status, occupational therapists had no choice but to do the same. The most significant point illuminated by these respondents was the acceptance that universities, rather than the professions, now have power over healthcare education. The business ethos was driving universities to find ways of expanding economic opportunities such as reducing attrition rates and introducing Masters level entry. The effect was that occupational therapists' ability to control professional education has been weakened.

SUMMARY AND DISCUSSION

Most of the practitioners, educators and COT representatives thought that university based education was beneficial and appropriate, relating the advantages to the idea that having a degree enhanced the status of both the individual and the profession. Among the practitioners there was recognition that a diploma now has little standing and there was a need to follow other reference groups. A few considered that, pursuing an occupational therapy degree offered an opportunity to achieve a status that may not have been reachable by any other route. The COT representatives indicated that there had been little reflection about the consequences of placing education in universities. The decision was forced when responsibility for funding was transferred from the Department of Health and Social Security to the Department of Education and was based on the need to follow others in striving for academic credibility. Some of the educators and COT representatives did not think that the promised status had been forthcoming and whilst some educators thought that graduate qualification should attract more candidates, this has not been borne out.

In contrast, some practitioners thought that the fact that others had moved to graduate education was not a good enough reason for occupational therapy to do the same and there were many expressions of concern. For example, the screening procedures have been weakened. Concentration on academic ability could attract the wrong sort of person into the job. High entry requirements were not conducive to attracting appropriate candidates and may deter potentially good ones, a view with which both the COT representatives and educators concurred. Practitioners found it difficult to fail students on fieldwork placement and at the same time universities were under pressure to retain everyone. Because it is a profession in short supply there was a temptation to have a quantity of students at the expense of quality. This was regarded as poor impression management. Practitioners and educators were aware of people who in their opinion, should never have qualified. Nearly half of practitioners thought that graduate training did not prepare occupational therapists for the job because it failed to teach the appropriate skills. The result was that new graduates often struggled to adapt to the work situation initially at a time when the need to work speedily and efficiently from the outset has never been greater. The risk to practical skills was acknowledged by all groups but whilst the COT thought that standards of education were variable both they and the educators agreed that pressure to reduce practical skill training could be resisted.

Yet, almost half of the practitioners were concerned that university based education has meant that academic study was prioritised at the expense of practical skills. They believed that knowledge emerged from practice and that educators were not driving theory with realistic practice in mind. They thought that concrete theory was most useful and that more effort should be made to teach applicable skills in university, rather than abstract theory. The fact that the practitioners found patient contact to be the most rewarding aspect of their work suggests that their main interest was in performing the job well but too much emphasis on academic theory has implications. Eraut (2000) made a distinction between 'espoused theories' developed within education, representing an image that a profession wishes to portray and 'theories in use', which are developed implicitly to cope with real practice. He argued that espoused theories are too idealistic to be attainable, leading to scepticism, frustration or burnout amongst professionals. The COT representatives agreed that there was division between practice and education but the views of educators were mixed. One thought there were already strong links between theory and practice, another disagreed and yet another thought that theory should be practice-based and not chosen because of its perceived status. Such challenges facing higher education were raised by Higgs & Edwards (2002) and in the light of these findings, appear to be well founded. They recommended that educators and practitioners should cooperate to build curricula relevant to the reality of practice, which would prepare students for the real world. The practitioners were saying that education, as it is, is built around the need to be academic, which is at odds with what the practicing membership thinks is necessary. When this is considered in relation to the difficulties of failing students the implication is that the universities are not being

effective gatekeepers to the profession by not preparing students adequately for practice and in allowing too many unsuitable people to qualify. Whilst university education may have brought an improved social position any benefits to society are outweighed by the disadvantage of producing technically unskilled practitioners.

Practitioners perceived that occupational therapists were losing the power to control education into practice in favour of the higher echelons at universities. The COT members and the educators believed that control of training into practice was professionally led, albeit within constraints from the universities, but the CPSM cohort agreed with the practitioners, that the universities had the greater control. Certainly there was pressure to comply with university business plans, which compromised the implementation of skills teaching and the ability to deny entry to the profession of those deemed unsuitable. Universities have exercised power in a number of ways and the gate-keeping role of professional educators has been weakened. Both practitioners and COT representatives saw variations in standards of education. In this sense university education was perceived to be failing in its capacity to symbolise competency, which must, according to Larson's (1977) analysis, weaken its marketable position.

The analysis so far has shown that monopoly of a unique skill and ensuring competence has been problematic for occupational therapy. The next characteristic of the professional symbol, having controlled education, is to control entry into practice. The following chapter will address how this has been implemented for occupational therapy.

CHAPTER 6 – FINDINGS

Data showing the initial coding and categories for entrance to the profession are presented in Appendix 8.

ENTRANCE TO THE PROFESSION

Having claimed expertise in a particular skill and demonstrated the superiority of the education process by making it difficult, competence became the marketable factor for the professions. Becker's (1977) third dimension of professionalism concerned the idea that, in order to manage this competence, entrance into professional practice must be strictly controlled and in the hands of professional members. Professions need to find a market for their commodity and an alliance has developed between governments and the service professions. Whilst the professions argue that competence is a matter of public safety, theorists interested in power strategies take a different view. Johnson (1972) and Wilding's (1982) analysis of the mediation type of control, for example, led them to suggest that the state needs the professions to perform its social welfare commitments and the professions need the state to enforce licensing and allow them a monopoly of the market. The relationship is one of mutual dependence. Johnson (1972) argued that when the state became involved in welfare provision it became incumbent on governments to be more involved in regulation of the way the service was provided. This was a cause of tension for the professions; did they have to sacrifice control for monopoly of work? They needed to persuade the state that the occupation was organised to control itself without abusing its privilege. Training courses, validated by the professional association, and requiring students to pass difficult examinations, were assumed to result in practitioners of equal competence and under those circumstances the state agreed to give the profession the monopoly of work covering their expertise (Wilding 1982; Freidson 1994). Sanction was given for the names of individuals who had the appropriate qualification to appear on an official register.

Through state registration, the public would be protected from the incompetent or immoral and qualified personnel guarded against unfair competition (Moore 1970). An additional assurance of safety, making a degree of self-regulation feasible, could be provided by the use of screening criteria, to ensure good character and trustworthiness (Freidson 1994). Although state control of licensing and registration weakened self-regulation the professional bodies could still have an influence by advising the government on issues relating to registration (Moore 1970). They also regained some control by aiming to win the right to ban unauthorised practice of their skills through 'protection of title', by which potential competitors are excluded and work opportunities restricted solely to the licensed (Freidson 1984).

State registration was an aspiration for all welfare professions but writers such as Wilding (1982), echoing Goode (1960) earlier, suggested that demands for

licensing usually came from the professions themselves rather than a worried public and should be regarded as attempts to secure economic advantages. He pointed out that the professions' relationship with the state offered financial security, as they no longer depended on clients for their income. Thus, he argued, the professional could concentrate on the client's needs but was not obliged to satisfy the client's wishes. Johnson (1972) thought that the state, through the service professions, decided what was 'in the public good', which limited consumer choice. Freidson (1994) took a different view arguing that regulating the conduct of practitioners was the point at issue and where an occupation provided a good standard of service monopoly of the market was an acceptable by-product. Witz (1992) considered that, because state registration was an exclusively male prerogative, it was used as an exclusionary device to women until the twentieth century when, once women did start to seek state-sponsored registration they used 'proxy male power' to further their cause. This was in fact the case for occupational therapy.

STATE REGISTRATION FOR OCCUPATIONAL THERAPISTS

Occupational therapists had a long battle to achieve state registration. Larkin (1983) detailed the ways in which the British Medical Association (BMA), fearing a loss of control, resisted the efforts of medical auxiliaries as they were called, to win state registration. The Cope report (Ministry of Health 1951) was the result of an investigation into the supply, demand, training and qualifications of medical auxiliaries, including occupational therapists working in the NHS. However, the auxiliaries were concerned they would not have the power to govern themselves and rejected the proposals, which included calls for a statutory body. In 1954 The Ministry of Health recommended negotiations with the auxiliaries, who decided that it was in all of their interests to unite in their moves for state registration. The result was a draft scheme for the Professions Supplementary to Medicine Act (Ministry of Health 1960) setting out the purpose of registration, which was to identify those who were qualified for employment in the NHS. The Act, which was passed in 1960, required the setting up of a council, boards and disciplinary committees for each of the re-named paramedical professions which at that time included; occupational therapists, physiotherapists, chiropodists, dieticians, medical laboratory scientific officers, remedial gymnasts and radiographers. The council was accountable to the Privy Council, which had substantial powers in disciplinary decisions of professional bodies, approval of training courses and the recognition of qualifications (Larkin 1983).

From the point of enactment, all paramedical professions wanting to work in the NHS were required to be state registered. Hugman (1991) argued that this consolidated professional status but in exchange for a limitation of autonomy. The paramedical professions were still under the authority of the Privy Council and dominated by medicine but not to the extent that the BMA had wanted. State registration was accepted on those terms (Larkin 1983). Medicine had a high profile in the composition of the council and boards and therefore the decision making. Until the 1980s, many articles published in the British Journal of

Occupational Therapy were written by doctors rather than by occupational therapists (Hagedorn 1995). In 2001 there were 12 boards and 34 members of the Council for Professions Supplementary to Medicine (CPSM), ten of whom were medics: a demonstration of the continued dominance of the medical profession. Hall (1975) and Hugman (1991) argued that the dominance of medicine in the governing bodies for the professions allied to medicine meant that the government, in fact, used the more powerful profession of medicine to apply some regulation to the paramedical professions.

In 1999 a new Health Act superseded that of 1960 which led to the creation of the Health Professions Council (HPC) in 2002, replacing the CPSM. The term 'paramedical' has been substituted for 'allied health professionals'. This council is smaller comprising directly elected practitioners and a strong lay input. It has revised legal powers in the following areas:

- Setting and maintaining high standards of continued education and training
- Complaints
- Discipline
- Council members who are not professional (lay members)
- Regulation of other professional groups
- Protection of titles
- Greater consultation.

(Health Professions Council 2002)

There is less medical control although, interestingly, any new occupational group seeking regulation will be required to demonstrate a number of features including the application of a defined body of knowledge and practice based on evidence of efficacy. A good test of efficacy, it is stated, is 'acceptability to the medical profession' (Health Professions Council 2002).

In order to understand the practitioners' views, about state registration and its relationship to competence and control of work, they were asked the following questions:

- Have you ever given much thought to state registration? What does the term mean to you? Is it important do you think?
- How do you feel about protection of title for OT's - the legal enactment that someone without a state-registered qualification cannot call themselves an OT?
- I wonder what would happen if people with a criminal conviction - say, a benefit fraud, were allowed to train as OT's?

THE VIEWPOINT OF PRACTITIONERS

State Registration

For 19%, the distinction between state registration and protection of title was confused. When asked about the former they often talked about the latter, as in this example.

OT11 (mental health): You know, you hear of people who claim to provide... A few years ago... there was quite a lot of people claiming to provide occupational therapy... Nursing assistants who in a few hospitals, used to provide occupational therapy erm and that was an issue where I was working earlier so I think that it is important that we do have a state registration.

State registration was such an integral part of being an occupational therapist working in the NHS that most practitioners, as in the following quote, barely gave it a thought.

OT17 (community): I'm not really aware... the form we've got to hand in every year?

There was awareness that state registration must be important but the reasoning behind it was little understood, other than that it was necessary to enable practice within the NHS or as a symbol of professionalism. Fourteen percent of the practitioners were unclear of the purpose of state registration. As might be expected, this lack of clarity was most evident amongst junior staff, which was the case for this practitioner.

OT25 (community): I suppose really if I'm honest I haven't given it a great lot of thought [chuckle] I just fill in the appropriate papers at the time and er... which enables me to work.

When asked to reflect, 64% thought that state registration indicated that the holder was competent to practice. In this extract the importance of the professional body being involved in regulating standards was highlighted.

OT32 (community): It basically tells the people who we're being employed by, that you have reached a certain standard and you're registered and you're covered and you've got the backing of a professional body.

This practitioner emphasised the need for professionals to be judged by other professionals.

OT18 (mental health): The fact that when people know you're state registered there's an acknowledgement that you've gone through a

recognised period of training, you've been assessed by professionals... you know in as many ways as possible... I suppose that's good.

There was universal agreement that the importance of proving competence was that it protected the public from unsafe practice, a point made in the following quote.

OT35 (mental health): I think it is vital that the public are protected... and there is a body responsible for overseeing their protection... I think it's very right that that body has the authority and the erm legal right to withdraw registration. So, protects the public from poor or malpractice I think that's very, very important.

Such views were notwithstanding concerns about the education process. Two practitioners expressed the opinion that, with diplomate training, there was an expectation that once qualified, students would be competent. The following quote laments the fact that this no longer seemed to be the case.

OT2 (community): At the end of the day you would be competent and I think we believed that... I think somehow you did believe that, when you came out... at that point. Now I think that's different with today's students because they will actually come out and say 'I know nothing...' you know quite up front... 'I don't know how to do a basic... ADL assessment haven't done one... did four specialist placements [laughter] didn't do anything else'.

Mindful of doubts about whether or not graduate education equips practitioners with the necessary skills for the work, 19% thought that state registration should involve more stringent regulation of standards. The following extract was typical.

OT29 (physical): I think it's [state registration] giving us license to practice... but then that's like saying we're competent to practice and... that needs checking at the moment.

Hall (1975) anticipated that once government assumed a greater financial role in service delivery, regulation would increase and the Labour government has done just that. The freedom of the professions to decide who is able to practice has been undermined, as the state has become more interventionist in monitoring standards (Neal & Morgan 2000). Allied health professions are now influenced by the structures set out in the government strategy *A First Class Service* (Department of Health 1998), including clinical governance, National Service Frameworks (NSF), the National Institute for Clinical Excellence (NICE), and the Commission for Healthcare Audit and Inspection (CHAI). Clinical governance has been reinforced by the Health Professions Act (Department of Health 1999), which has emphasised the need to demonstrate continued competence (Burley 2001). Registration is now driven by government controlled, formal

demonstrations of competence. Some practitioners welcomed this, as this quote reveals.

OT19 (physical): I think with the new Health Act, I think it's probably going to be more useful erm... I think up until now it's just been something that we have to do, I don't think there's been any particular relevance for me other than I needed to have that piece of paper.

In brief, some practitioners had blurred the distinction between state registration and protection of title. It was not an issue that took up much of their time but they assumed that it symbolised competence. Most saw the certificate of state registration as the passport to working in the NHS. There was a sense that it was important for members of the profession to have control of regulatory processes. However, in practice, concerns that newly qualified occupational therapists were not always competent, were repeated. Some considered that self-regulation had proved inadequate and therefore more government control was seen as positive change. This suggests that the practitioners believed the focus on competence was to ensure public safety, rather than to secure work for them. To further explore this issue their views were sought on trustworthiness and honesty as essential characteristics of an occupational therapist.

Character Screening

A doctor has access to knowledge, which would in other circumstances be considered intimate; 'guilty knowledge' as Hughes (1981) calls it and they must be trusted not to abuse that knowledge. Professional work is often like this and the public would be in danger if there were no regulations. Therefore the ability to demonstrate trustworthiness, to state and public, became a necessary characteristic of professional intervention (Larson 1977; Wilding 1982; Freidson 1994). Another assurance that a profession, as an organisation, was able to control itself could be given by using screening criteria to ensure that recruits were of good character and trustworthiness (Freidson 1994). Prior to working in the NHS, references attesting to the good moral character of the candidate are required but Moore (1970) suggested that these were seldom checked properly. It is, therefore, interesting to note that as recently as 1998 the report from the Council for the Professions Supplementary to Medicine, reminded all higher education institutions, about the importance of requiring evidence as to good conduct, from students applying for places on approved courses leading to state registration. Evidently, some NHS organisations had refused to accept some students on fieldwork placement because their checks had revealed 'unspent' convictions, which had been overlooked by the universities. Establishing good character remains a requirement to be met by registrants under the terms of the Health professions Council (Health Professions Council 2003).

The practitioners were asked to consider whether or not someone with a criminal conviction, such as a benefit fraud, should be allowed to enter occupational therapy education. Seventy five percent would be in a dilemma. They were

reluctant to be judgmental but at the same time knew that trustworthiness was essential for a professional image. This widespread view is reflected in the following quote.

OT31 (community): I think it is very difficult because we talk about... We *do* talk about people who are disadvantaged... then not being able to get a chance... you know... either... And certainly when you go for a job and particularly if you work with children... you have to have your police record done anyway er... I think, I must, I mean I'm not very au fait with it in terms of what excludes you and what bars you and what the time limits are in which convictions will have been wiped off erm... But I guess it would be very difficult... I don't know, I'm thinking about justifying training somebody and putting all that money into training somebody who you *know* isn't going to be able to work in a high percentage of the profession... I think that is quite hard because you *need* to be trustworthy.

Fourteen percent took a more pragmatic view and argued that trustworthiness must never be compromised. The importance of this is explained in the next quote.

OT27 (mental health): You've got to have certain standards... I suppose nobody's perfect but then... I think you've got to err on the side of caution. It's got to be that as far as you know people don't have a criminal record and if they do have and admit to it it's got to go before a... erm a higher level... But I think we've got to say no... again nobody's whiter than white but it's a profession and it's maintaining a professional image.

Eleven percent of the group was prepared to say that they would extend their non-judgmental principles to recruits into occupational therapy, although this practitioner was inclined to monitor more carefully, anyone who had a conviction.

OT10 (community): I think people have their pasts and people can, should be allowed to move on from that but I think it would mean... we talked about the supervision [earlier] it would need monitoring... but that's not personal.

In general, the virtue of self-regulation was brought into question in the light of this group's reflections on checking the moral character of prospective occupational therapists. Only a small percentage would consider denying access to those with a minor criminal conviction. Most would find it difficult. Largely this was because the image of practitioners presented in public, was one of acceptance, unconditional regard and tolerance towards patients. There was unease because, on the one hand this image should be extended to all, whilst on the other, patients must be protected from the unscrupulous. The dilemma would be more clear-cut if maliciousness was involved or a prospective candidate had

committed a major crime, but a lesser one gave rise to some anxiety. A few would allow such people into the profession but with a heightened awareness to look out for potential problems. That said, the respondents were reflecting on a hypothetical circumstance and it is not, in fact, the responsibility of practitioners to undertake character screening; the reality may therefore be different. However, it damages the impression that the practitioners' first and foremost concern was public safety, so what was their perspective on protection of title? Does it serve the public or the profession?

Protection of Title

The new Health Professions Council has bestowed to the allied professionals, protection of title, a type of social closure by which potential competitors are excluded and work opportunities restricted solely to the state registered (Freidson 1984). This was considered to be one of the main benefits of the new Act (Craik 1997). It is now no longer necessary to prefix 'occupational therapist' with 'state registered'. However, it seems that may not have strengthened professional autonomy. The NHS Modernisation Agency, part of the Department of Health, advocates the redesigning of roles across a number of health and social care settings, through its Changing Workforce Programme (Workforce Matters 2002). Governments need knowledge and expertise to satisfy the welfare needs of society but they do not need to maintain professional boundaries. Role redesign allows staff to renew and extend their skills and cross boundaries of responsibility. For example, the role of 'clinic assistant' combines the work of occupational therapy assistant, physiotherapy assistant and nursing assistant in healthcare for the elderly (Workforce Matters 2002). The aim of providing a more flexible and responsive workforce may be laudable, but it conflicts with the promise of tightening of professional boundaries, through protection of title.

When probed about protection of title 19% of practitioners considered it to be a good idea without much expansion about the reasoning behind it. One of the effects of professional education being long and difficult was that students delayed their earning potential and made a heavy investment of time and effort to achieve qualification (Hughes 1981). Some have argued that social closure is a way of motivating people to do this. Once they have qualified, financial remuneration and security of work can be promised whilst society benefits from the expertise that has been acquired (Freidson 1984). There was evidence, amongst practitioners, to support this view; 47% considered that protection of title was a way of excluding those who had not been through the same process of education. This characteristic view was expressed in the following quotes.

OT18 (mental health): I must admit I think that's a good idea. I've been around a lot of people like... [a prison]... they used to have occupational therapy... no sign of any OT's though... I know they're there now... And all sorts of technical instructors and people who, you know were doing a good job... were considering that they were part of the OT profession, I think that was difficult... yeah that can cause problems.

OT9 (physical): I've got a degree! [Tapping the table] yes it should be protected people shouldn't be able to just to sort of like almost fall into it.

OT25 (community): Oh yes I think we should protect our own title to prevent other people from erm you know, trying to do our job or saying that that's what they are doing erm when actually they're not.

Another 28% considered that protection of title offered reassurance of competence although none of the physical occupational therapists brought up this point. It seems that they looked on it more as an exclusionary tool. The following practitioners were concerned about public safety.

OT13 (community): It gives patients some reassurance that you're... You know, if you say you're an occupational therapist then some Board has said that you *can* say that you're an occupational therapist and you're not just any so and so knocking at the door... You know, there's obviously a lot of people that do just knock at the door and... con people.

OT35 (mental health): ...It unifies us as a body... but like I say it's also... if I understand this correctly... it's also about ensuring protection and safety of Jo public as well.

Most practitioners then, thought that protection of title was a good idea although some were not sure why. Almost half thought that they had worked hard to achieve their title and deserved uncomplicated access to the work. Protection of title seemed to have more to do with securing work for most of the group but there were those for whom safety of the public was the main consideration.

In summary, state registration was a taken for granted license to practice and was assumed to signify competence in the interests of public safety. Whilst judging competence should be a matter for occupational therapists, self-regulation was considered to be weak and therefore more government intervention was accepted as necessary. This inability to police regulatory procedures effectively was reflected in the practitioners' views on character screening. They were unwilling to exclude potential occupational therapy candidates for a minor criminal offence, even though they knew this was counter to the professional image. Although there was a small proportion of people whose primary concern was keeping the unscrupulous away from patients, to a large extent protection of title was regarded as insurance for work availability.

While regulation is now statutory it is run independently by an elected council, which includes members of the profession (Health Professions Council 2003). There are strong links with the College of Occupational Therapists (COT), who are likely to want to influence issues pertaining to state registration and so on. The views of the COT representatives, on control of entry to the profession, were sought in order to compare and contrast them to those of the practitioners.

THE VIEWPOINT OF the COLLEGE of OCCUPATIONAL THERAPISTS

State Registration

Interviews with COT members were undertaken as the Health Professions Act (Department of Health 1999) was being negotiated. It was a time of reflection about the purpose of state registration. One respondent highlighted its importance in protection of the public but considered that occupational therapists were also beneficiaries in terms of status.

COT6: I mean the positive side of it [state registration] is that you have a whole system, which says this is... These are a group of people doing a job which is important enough to say... have to have a... level of training... have to have a level... at which they act in this sort of way and they can be sanctioned... They can be removed from that if they do it wrong... Because not only is that protection of the public it's important enough for the profession to be able to say... 'We're quite important people' and that's... that's real and that's necessary.

Maintaining professional control was a consideration during negotiations for the Act. This respondent highlighted the tussle between the responsibilities of the statutory body (Health Professions Council), which is independent and the professional body (College of Occupational Therapists), which is partisan.

COT1: I suppose the College... I suppose this is where there's a tension between the statutory body and the professional body. Because perhaps the professional body...erm... would like the power of the statutory body... er where I personally think the statutory body should be completely separate and independent from the professional body. Because the College's purpose is to promote the profession... it isn't to... protect... the public as the Occupational Therapist's Board is.

Just as there was strength in unity during negotiations for the 1960 Act, four COT representatives reported the effort made to collaborate with other health professionals to uphold professional control and have an influence during proceedings for the 1999 Health Act, as explained in the following quote.

COT3: The College and some of the PAMS and the BMA we are... we meet informally in this er parliamentary group. And actually the BMA takes a lead because they have a legal department starts phoning the... House of Lords or whatever so we've got... pretty organised. [Name] sits on that to represent us. [Name] is the head of department and when he couldn't... so I can go... now. That's just to keep track of each session while they are reading the Bill... and lobbying the MP's there... to make sure they ask the right questions. We have to be... very smart politically and a lot of it, there is quite a lot of political work to be done lobbying at the crucial stage.

This respondent thought that state registration had become meaningless in terms of what it did or did not guarantee and regarded tighter government regulation in a positive light.

COT2: Well the Health Bill might make it [state registration] more important and I do fail to see at the moment... to date how it's been important apart from... being one of these martyrs... of 1960 or something... People say you're with the professions because... it says there...(3)... so what? ... It may become more effective with the new legislation.

The reason behind such thinking was the realisation that occupational therapists have not been effective regulators of competence and have shied away from eliminating the incompetent.

COT2: I think this issue of regulation... Making sure people are... perhaps weeded out who are incompetent... More of that...(3)... erm perhaps placing some more regulations...on us. That wouldn't be a bad thing, the funny thing about occupational therapy is there's no...erm... very lacking in confidence profession with... discipline... erm people operate very autonomously I keep saying that and people don't believe me but it's **true.**

Another four respondents also referred to the importance of the professional body's role in maintaining competence of its members. This member reported the effort made by COT to have an influence in government negotiations.

COT3: The other thing that we were working very hard on... oh is erm... was to ensure the competence of... continued competence of occupational therapists... somebody who qualified 20 years ago and never practiced and then expected to move straight into a senior job when they came back.

However, this one thought that those efforts needed to be more strenuous.

COT7: I think there's got to be some... some way of ensuring that you've maintained your competence and that you demonstrate... your competence and I don't think we've worked any way closely enough with... We've involved them in debate... but I don't think we've worked anywhere closely enough... as a Council... Now yes there's work going on within the Boards but again...Council's not taken ... a particular interest.

In summary, state registration was considered to be important not only in terms of status but also in symbolising competence, although how accurately it did this was debatable. COT strove to be influential and to gain some control over the provisions made in the 1999 Health Act. They collaborated with other, bigger and

more powerful groups, including the British Medical Association to enhance their position. Competence was considered a major marketable factor and it was acknowledged that this had not been previously well managed. Therefore, government intervention was welcomed. In the event there are now structures in place to monitor competence more efficiently. The HPC has published standards of conduct and of proficiency for occupational therapists, after consultation with COT among other stakeholders. The government has proposed in *Agenda for Change* (Department of Health 2003) a national framework covering pay and conditions for most staff in the health service. It is underpinned by an NHS specific job evaluation scheme based on Knowledge Skills Framework. This is a competency framework linked to the standards upon which, career development is dependent (Health Professions Council 2003; UNISON 2004). If registrants do not meet the standards of conduct, if there is incompetence or in cases of police cautions and criminal convictions, or in cases where ill health compromises an individual's fitness to practice, action can be taken (Health Professions Council 2003). It remains to be seen what influence this will have on the competence of occupational therapists.

Given that the COT representatives recognised that occupational therapists were poor disciplinarians, what was their position on character screening?

Character Screening

Three respondents reported that it was the role of the statutory body, not COT to dictate the need to ensure 'good character', a point made by this respondent.

COT1: At one level the College can't do anything... because that's not the College's remit, that's the Occupational Therapist's Board's remit they're the one's who are responsible for discipline and investigating the disciplinary cases

According to this respondent, it was the responsibility of the universities to scrutinise prospective candidates. However, COT could have an influence by publishing policies on standards.

COT3: We're not actually the admission body if you like, it's the... it's the... In terms of physically saying 'no you cannot go on this course because you've got a criminal record' it is up to the individual... er ... educational establishments to say who they will take in their course. One might admit someone who is 55 years old, another one wouldn't... But what we *can* do is actually er produce er work together with the erm... the joint validation body to determine... er. Together erm with the... standards we expect from... the practitioners erm... and indirectly the sort of people who are likely to be able to fulfil such standards. So... in terms of keeping people who would be a danger to the public out erm... we cannot it would seem to me it's down to the... admission procedures of the school.

Five respondents reported the importance of police screening for registrants but in their opinion, there was often a lack of screening by the universities, usually due to commercial pressures, as reported in this quote.

COT6: A lot of responsibility has to come down to the people doing the... selection and interviewing on the ground. And I know that there are different pressures in different universities for how that is and in some places I hear... that the... the main criteria is getting the right number of people through... on to courses.

One respondent reflected on the difficulties of ensuring public safety whilst not denying an opportunity to a potentially good therapist.

COT7: Everybody... has to have a police check and anybody... who... maybe you know years ago they've done something that's on record, we look to the registrar for advice on whether they're allowed to continue on the course... I think the difficulty is isn't it that... anybody can become ill... things can happen to anybody... I think we have a personal responsibility too... I also know that when you're interviewing there are people who...you just know...are going to be super erm who might not meet this er... little template of what they're expected to be.

To an extent, ensuring trustworthiness was considered to be the preserve of the statutory body and individual universities but it was important for COT to be involved in publishing standards of practice. Screening candidates prior to allowing them into occupational therapy education was a necessary procedure but the business orientation of universities meant that there was a real risk that someone with a minor criminal conviction could slip through. There was a hint that some COT representatives would not be averse to allowing a doubtful candidate into the profession, providing they possessed other positive characteristics, so there was something of a mixed message about the need to screen character strictly.

The roles of COT include the promotion and marketing of the profession. One of the ways it does this is through an emphasis on the competence of its members. The ultimate aim is to gain employment for occupational therapists so COT had a vested interest, as the organising body to aim for protection of title but how was this pursued?

Protection of Title

The effect on professional bodies, of greater government regulation can be that they become limited to protective functions and public activities (Carr-Saunders & Wilson 1933). Certainly during the interviews of the COT representatives there was evidence of strong and active pursuit of protection of title. The following quote was typical.

COT3: Working with the government over this new Health Bill er our main concern was to ensure that the title is protected er not just state registered occupational therapist but occupational therapist that title to ensure that er... yes that would be regulated. Nobody else could call themselves occupational therapists.

Protection of title was considered important to eliminate 'unruly practice' but also to address the threat, no matter how small, of encroachment of occupational therapists' work by the unqualified, a point made in this quote.

COT6: It's important to occupational therapists it... it's rather more important to people like chiropodists and physiotherapists. Chiropodists have a very very large... and unruly private practices of non-registered practice which they... they really do need to get er sorted out. Physiotherapists have a very large... private practice...erm. Occupational therapists are more and more in private practice there aren't so many examples of people trying to use the title and usurp the job but never the less it's very important to be able to say being an occupational therapist means this and it can't mean that.

As far as COT was concerned, state registration was a licence to practice but its capacity to signify competence has been open to challenge in the past. This should change with the measures introduced through the 1999 Health Act. 'Good character' was considered desirable but the responsibility of searching for it was placed at the doors of the HPC and universities. The role of COT was to produce documentary evidence of the type of person required. Although one of the COT representative was prepared to accept someone into the profession with a minor criminal conviction, providing they showed other strengths, there was general concern that the universities were not implementing police checks on prospective candidates with sufficient rigour. Protection of title was pursued vigorously and has now been achieved, the main aim being to secure work for occupational therapists.

These were the views of the organisation. The educators were likely to have a different perspective on control of entry to the profession: so how did their views compare to those of the practitioners and COT?

THE VIEWPOINT OF EDUCATORS

State Registration

All four educators thought that state registration was an important symbol of competence signifying reassurance for the public. They welcomed the tightening up of regulation, which is inherent in the Health Professions Act (Department of Health 1999), as this educator reported.

T3: I think it is... very important...(1)... that a person who...(1)... is practicing... as a professional...(2)... is considered... suitable to do so... (2)... and I think the state registration... and the criteria... that... the Health Professions Council... and the monitoring... that is going to be... tightened up with that...(4)... I think it's very important for the protection of the public.

Character Screening

One respondent did not think that a minor misdemeanour should preclude an individual from registration. However, all of the remaining educators emphasised the necessity of prospective students to undergo character screening, particularly clearance from the criminal records' bureau. This educator found the directives, drawn up by the professional and statutory bodies to be helpful.

T2: We... do have... guidelines for professional suitability... and we do make it very clear in our document that em... er... Those are based on sort of OT guidelines... er professional guidelines... em plus our own... They're sort of related to education and... and we actually have them actually... very clearly spelt out... you know I think it's two or three pages...(1)... certainly a couple of pages it's quite... it's not just a paragraph.

This respondent highlighted an interesting point: as educators they are removed from direct patient contact and there could be a dilemma regarding whether their duty of care lay with the student or patient. This extract related to the outcome of a re-validation exercise on the curriculum offered by a university.

T2: One of the things they [external examiners] wanted more on was professional suitability... Which is interesting. Which means that perhaps they are very aware that it is a very, very important area... em... All of these things... em... are... are important... Also you know talking...(2)... em... that educationalists need to talk... more about the rights of clients... and a little bit less about the rights of students... People's rights do conflict... and we of course are very, very aware because... We are professional from an educator's point of view... and the rights of students are paramount... to us... as educators as professionals... But then we have to look and say yes but this student... isn't the most important going

on placement... the most important person is the client... they get to be meeting the clients... they're later going to working with.

One of the educators thought that character screening could go too far but most thought that it was vital. They valued the strength of public policies on standards published by the Health Professions Council and the College of Occupational Therapists, as well as their own. In their opinion the universities rigidly upheld character screening. Educators were removed from direct patient care and this created unresolved tension regarding duty of care; did they support a student who might be guilty of a minor misdemeanour but deserved a chance or did patient safety take precedence over all else?

Protection of Title

Protection of title was important for these educators both for exclusionary reasons and also because occupational therapists have 'earned' that status. As in this case, several drew attention to incidences where people had appropriated the title 'occupational therapist' without justification.

T4: I mean I come across this with... uhm... residential homes...(3)... you see it in brochures sometimes... occupational therapy [laughter]... ah...(1)... and if I see it... and I go in there... I say... who's an occupational therapist then? ...(2)... 'Oh Doris does it here...(2)... she does a bit of craft [with them]'...(4)... you know...(1)... so yeah I'm all for it... protecting the title...(1)... think... we should be proud.

The educators then, viewed state registration in terms of it being an assurance of competence and of protection of the public but they too, thought that procedures needed tightening up. Most thought that universities implemented character screening stringently and good use was made of published directives regarding standards. However, because of the dilemma over whether the greater responsibility lay with students or patients, there was a tendency to err on the side of leniency towards the student, for at least one educator. Protection of title was largely seen as a reward for effort and a means to secure work.

Attention was then drawn to the viewpoint of the Council for Professions Supplementary to Medicine (CPSM)

THE VIEWPOINT OF the COUNCIL for the PROFESSIONS SUPPLEMENTARY to MEDICINE

State Registration

State registration was considered a symbol of competence and public safety, as this respondent explained.

CPSM2: It's imperative and I don't think any government in this country would ever believe... that it wasn't in their duty to ensure that it's citizens were protected from erm... practitioners who might do them harm.

As far as this respondent was concerned, there was absolute confidence in the competence of an individual completing a UK validated course.

CPSM2: Well for us... for somebody trained in the UK... we would have no qualms, no query about registering every single person that comes out of a university having... passed that degree.

However, the same could not be said for those who qualified abroad but wanted to work as occupational therapists in the UK, a point made in the following quote.

CPSM2: The difficulty comes with overseas people because we don't have... any handle on the education programmes in the rest of the world and I think that is... That is where the biggest part of our work is.

Neal & Morgan (2000) argued that European legislation has led to closer government regulation of the professions throughout the European Union. An occupational therapist, for example, is free to work anywhere within the European Union without taking further qualifications pertinent to that member state. The same applies to European occupational therapists wanting to work in the UK. The loss of professional power to regulate those who did not qualify in the UK was noted in this extract.

CPSM2: Everybody outside of Europe... erm. They send in all their paperwork which is quite extensive and... If the paperwork demonstrates that, yes they are an occupational therapist then they are invited to sit an assessment... Which [a university] handles for us on a contractual basis erm which takes place four times a year and... if they pass that assessment then... they get their registration. Europeans we can't do that... we can't make them sit an assessment... Europeans we can only offer them one of two things... a period of adaptation or... a competency... it's not called a competency test... I forget what it's called... something like a competency test... they all of them... nobody yet asks for that they all go for... periods of adaptation erm... We have a much...erm... more detailed... form for the Europeans which gives us a lot more detail about their actual course... And... it goes to assessors who then assess them

each individually and will make the decision for us about whether that person is fit to be registered or not.

There was an understanding that the newly configured Health Professions Council would work in conjunction with professional organisations. This respondent indicated that COT would have a collaborative role in establishing standards of competence.

CPSM3: What in fact it [HPC] does is... works with the professional body, which has produced... document guidelines... It wishes also to cease... to not to be ...too... supervisory in that... what was... right from the beginning expected from them wouldn't be supervisory but what we would actually be doing was monitoring them... ensuring the systems were there... what's now called quality assurance... It wasn't called that in 1960 but it's not a sort of detailed supervisory role... much more a... working with to ensure the standards are being met and so an awful lot is left to... the institution.

This respondent was keen to establish professional control.

CPSM2: I think there are some people in government and some... some civil servants who would like to see more control over what professions do... The way that we're set up at the moment they don't have any... and I think it's significant that... the new Health Professions Council will not be accountable to the Minister... It will remain accountable to the Privy Council... and we felt that, that was very important because the professional standards are outwith the political agenda.

State registration was unquestionably considered an important symbol to government, of competence and public safety, for CPSM respondents. They had faith that UK educated occupational therapists were competent but lamented the loss of power to control entry to those who were educated in Europe. The Health Professions Council is committed to developing standards of proficiency for registration, and the standards for education and training. In doing so they will work with the Quality Assurance Agency (QAA) and funding bodies and in collaboration with providers of education and training and professional bodies (Health Professions Council 2002). Through the occupational therapy board, these respondents envisaged that there would be strong professional member input in such matters.

Character Screening

At the time of these interviews, CPSM placed the responsibility for character screening into the hands of the universities. In the event of an individual failing to declare a conviction and successfully completing the course, CPSM was unable to deny registration, as this respondent explained.

CPSM1: Strictly speaking the Board has no ability to control that at all erm we have to rely upon the universities to screen applicants to courses to make sure... dangerous psychopaths aren't enrolled... and they aren't always successful. There are one or two [slips] now and then... We try to make sure... that students who graduate will be able to meet the criteria of the Rehabilitation of Offender's Act whereby... certain erm convictions debar some people from practicing for life in the NHS and all criminal convictions or cautions have to be declared in perpetuity. There's no time expired limit this is your... this is familiar ground to you. So we have to try and make sure the universities align their procedures to that... The bottom line however is if someone slips through the net we cannot refuse to register them we have no power under the Act.

However, this is no longer the case as the powers to withhold registration have been tightened up. The Health Professions Council has set up seven committees, four of which are statutory. One of these is the Conduct and Competence Committee whose role is to advise the Council on the requirements of good character and good health to be met by registrants and to consider any allegations in the interests of public protection (Health Professions Council 2002).

Protection of Title

Protection of title was far from assured during negotiations for the Health Professions Act (Department of Health 1999) but was supported by the CPSM, a point made in the following extract.

CPSM1: Government accepted in the abstract... that there was... patently a case for protection [of title]... Much more difficult task is persuading them to find time to do it and that's quite a different story that moves into the area of politics and public perceptions and ministerial lobbying and so on.

In brief, the CPSM respondents were the most confident, that state registration could be equated with competence. They took the view that control of entry into the profession should be in the hands of occupational therapists primarily. In their opinion universities had not in the past been successful in screening out inappropriate candidates and the greater powers of the HPC to de-register an individual at a later stage was welcomed.

SUMMARY AND DISCUSSION

Although there was an element of confusion about its meaning, practitioners regarded state registration as their license to practice. It was such an integral aspect of the work that there was a taken for granted assumption that it must represent competence in registrants. It was also assumed that occupational therapists were best placed to judge other members. However, on reflection they realised that when regulation was left to them, they were too lenient. Their main

interest was in protecting patients from the unscrupulous and therefore they acknowledged that outside regulation was preferable for objectivity. The CPSM representatives believed state registration to be a powerful symbol of competence and public safety. They advocated professional control of entrance to the profession, within government guidelines. Whilst there was faith that UK qualifications were adequate, it was considered regrettable that European legislation had weakened the powers to screen candidates from the EU wishing to work in the UK. Since this was the view of the statutory body it is reasonable to assume that this was in the interests of safety rather than exclusion. Strategies have now been implemented to address this problem. Several European countries are involved in an initiative to share information with regulatory agencies and the HPC hopes to host a central online register of people around the world who have been struck off or charged with misconduct (Clarke-Jones 2004). COT members thought that state registration was important in terms of symbolising competence but also for status, whilst the educators saw it more in terms of protection of the public.

The entire cohorts' enthusiastic welcoming of greater government regulation was revealing. From a sociological perspective they have acknowledged weaknesses in self-regulation. If this had not been addressed, the power of state registration as a symbol of professionalism would have been undermined because competence, eventually, could no longer be assumed. Greater government control of regulation serves as a public re-affirmation that the competence of occupational therapists can be assured. At the same time, COT made sure, during the negotiations for the Health Professions Act (Department of Health 1999), that the professional body would be influential in the processes of the HPC. In the event there is a collaborative relationship between the HPC, the COT and educational institutes (Health Professions Council 2002). Professional members have given reassurances to the state of their expertise, secured access to work and maintained their influence in all aspects of the organisation of the work.

The inability to be rigorous in regulation was reflected in the practitioners' views about character screening. They would find it difficult to reject someone on the grounds of a minor criminal offence but at the same time had worries about admitting a candidate into the profession who might exploit patients. Similarly, the COT members and educators, whilst accepting the virtue of character screening, admitted that the profession had been feeble in this respect. The COT and CPSM members had virtually placed all of the responsibility onto the universities and criticised their capacity to fulfil the task. Circumstances have now changed with the formation of the HPC, which has greater powers to handle cases of fitness to practice involving conviction and can take various courses of action from issuing a caution to de-registration (Health Professions Council 2002). This stance has reinforced the importance of rejecting any individual, before they enter the profession, whose past may hint at future deception.

Most practitioners thought that protection of title was a hard won and just reward for past effort. Securing work was a major concern although there was a fairly strong opinion that it also symbolised competence and was therefore important for public safety. This was notwithstanding the admission that the professions' ability to control itself has been questionable. The CPSM representatives supported claims for protection of title but acknowledged that this was of greater concern to the profession than to the state. The COT members and educators thought that protection of title was a victory for exclusion and due reward for lengthy and arduous education. In the light of the Department of Health's initiatives regarding role redesign the effectiveness of such a gain is debatable.

Protection of title is a privilege that has been gained in return for a commitment to demonstrable competence. State registration is one way of providing evidence of expertise but it is not enough on its own; trustworthiness and honourable behaviour are also important (Carr-Saunders & Wilson 1933). This explains why character screening is so important and also indicates why codes of ethics for professions are necessary. Precisely how this is so will be explained in the next chapter.

CHAPTER 7 – FINDINGS

Data showing the initial coding and categories for code of ethics are presented in Appendix 9.

CODE OF ETHICS

A code of ethics, with an emphasis on devotion to service, beneficence and condemnation of misuse of professional skills for selfish purposes has become another symbol that a profession can be trusted not to abuse its privileges (Becker 1977). Macdonald (1995) highlighted ethics and moral judgement as a defining professional characteristic, equal to knowledge, even for science-based occupations such as medicine. Carr-Saunders & Wilson (1933) believed that ethical codes acted as a public declaration guaranteeing not only the competence of professionals but also their honour. Codes of ethics are normally set by the professional associations, which strengthens their gate keeping role by guaranteeing the service orientation of members, their trustworthiness and in return, making them deserving of power and autonomy (Haug 1973). Wilding (1982) identified three ways in which such a guarantee worked: moral veracity, the ideal of service and colleague control of individual professionals. The service ideal will be addressed in the following chapter but all three are closely intertwined.

Tawney (1921) assumed that working in partnership with colleagues (collegiality), was an effective way of elevating group morality and was therefore, a legitimate governance mechanism, through which society was protected. Durkheim (1957) illuminated the link between professional ethics and morality. In his opinion, moral discipline was protected and gained authority through the collective power of groups such as professional bodies, which compelled individuals to act in a particular way and to a standard not common to everyone. It was a distinctive feature of professionalism that offences considered minor in public opinion, would be sternly dealt with through disciplinary procedures of professional associations. Individuals were driven to abide by rules of conduct because not to do so would bring disrepute, not only to the individual but the profession as a whole, which would 'damage collective interests'. It was this high level of morality, which placed professions 'outside the common consciousness' and gave them authority distinct from the business world (Durkheim 1957).

Goode (1969) and Freidson (1994) argued that codes of ethics controlled behaviour in ways, which helped to serve the aims of the profession, rather than governance. Both authors saw a conflict of interest between ethics and collegiality in that professional etiquette encouraged loyalty to all colleagues, including the incompetent. Thus, as a regulatory mechanism it could fail. Hughes (1981) suggested that the function of a code of ethics was much more complex than separating the good from the bad. The ways in which issues were dealt with

could be revealing; take 'professional misconduct', for example. According to Wilding (1982) it was the high profile of trust as an overt guarantee of noble intention that led to the professions' zealous handling of 'infamous conduct'. It was regarded much more seriously than incompetence because it represented an abuse of trust and once trust was diminished, power and privilege became unacceptable. But an incompetent practitioner could continue to practice unless a serious crime had been committed.

Elliott (1972) supposed that when offences occurred in the public domain or attracted publicity it was especially important to cite infamous conduct in order to present a public front and deter criticism of the professionals' ability to self-regulate. Wilding (1982) cast doubt about a profession's willingness to monitor the standard of work of its members. Even the functionalists, Carr-Saunders & Wilson (1933) found that, although the power to expel professionals who had committed a crime existed, this was reserved, in reality, for only the most serious offences. Becker (1977) argued that there could be a disparity between the code of ethics as a symbol and the reality. He criticised the degree to which unethical practice was covered up within professional communities. Similarly, Hall (1975) considered that the reality of practice did not match the standards of the codes, which are currently regarded with scepticism.

Nevertheless all modern professions try to establish a code of ethics early in the professionalisation process (Cant & Sharma 1996). They have been influenced by historical events, with elements from both status and occupational professionalism finding their way into current professional ideology. Moore (1970) suggested that, because of their different social origins, occupational professions were more likely to have written standards of conduct. It was considered unnecessary for the status professions to have explicit codes because their genteel origins would ensure that they behaved like 'gentlemen'. Their liberal education included values, which would not be out of place in a modern code of ethics: personal service, a dislike of competition, advertising and profit, a belief in the principle of payment to work rather than working for pay and in the service ideal (Elliott 1972).

Goode (1969) thought that it was important for the client to be familiar with the honourable, moral, professional role and to have expectations of norms for appropriate client/professional relationships. He saw a specific pattern to codes related to the service professions, where clients were likely to be vulnerable and there was a risk of emotional dependence on the service provider. When exploitation might be a temptation, ethical codes tended to be more explicit, dictating appropriate client/professional relationships, and disallowing the acceptance, as clients, of relatives or friends. Other behavioural norms included emotional detachment, (although judgement was necessary because this might be perceived as unconcern by the client), equity of service, putting the client's needs first and having the ability to refine what those needs were (Goode 1969; Haug 1973).

How does all of this compare with the code of ethics for occupational therapists? How does it deal with misconduct: does it aim to control behaviour in the interests of governance or to protect the profession?

OCCUPATIONAL THERAPISTS' CODE OF ETHICS

The Joint Council of Occupational Therapy Associations was set up in 1952, with the specific purpose of preparing a code of ethics and negotiation of state registration (Jay 1992). From 1962, all those taking the diploma in occupational therapy were required to sign a statement that they were aware of the code of ethics as a requirement of the final examinations. This is no longer the case: the code is now regarded as a guide for appropriate conduct and has no legally enforceable disciplinary powers (Wilcock 2002). Millerson (1964b) analysed the codes from 21 professions and found that they could reveal whether the direction of interest was towards protection of the public or the profession. He discovered that, for many, the greatest concern was over competition, with very little emphasis on service to clients or any duty to expose professional incompetence. Occupational therapy was not included in the analysis but a review of the codes reveals, in contrast, a strong inclination towards service orientation. Young (1995) noted that codes were rarely amended. According to Wilcock (2002) the occupational therapists' code was first reviewed as late as 1990. There have been subsequent reviews that have reflected changes in law and social values. For example, prior to 1990 patients' rights to view their case notes were restricted but legislation, including the Data Protection Act (Department of Health 2000b) gave rights of access to such records. All of the codes of ethics for occupational therapists have highlighted a moral dimension, the latest stating,

The code requires that practitioners discharge their duties and responsibilities in a professional, ethical and moral manner (College of Occupational Therapists 2000).

Although this code makes a strong, opening statement about occupational therapy being a protected title, there are sections on client autonomy and welfare, duty of care to the client, cruelty and abuse, services to clients, personal/professional integrity and professional competence and standards. More particularly, the section on professional integrity includes a statement that,

Under no circumstances must any occupational therapist who witnesses malpractice, whether by an occupational therapist or other professional, remain silent about it (College of Occupational Therapists 2000).

It appears therefore, that the intent is to guide members towards moral and client centred practice.

Under the terms of the Professions Supplementary to Medicine Act (Ministry of Health 1960), the regulatory body (Council for the Professions Supplementary to Medicine) had the power to cancel registration of an occupational therapist, only

in cases of infamous conduct. This was defined as 'behaviour serious enough to bring the profession into disrepute' (Occupational Therapists Board 1996). The Disciplinary Committee of the Occupational Therapists Board, on behalf of CPSM, was required by law to produce a statement of the kind of conduct considered to be infamous in a professional respect. In 1996 the statement consisted of four components. Two concerned advertising and confidentiality whilst the other two dealt with endangerment to patients or inappropriate relationships. For most people however, registration was assured for the duration of their career whether or not, they remained competent. Although the code of ethics produced by the College of Occupational Therapists is not legally binding there was an expectation that it could be used as a reference, along with this Statement of Conduct, to indicate the standards, which should be expected (Occupational Therapists Board 1996). In the 1995 code of ethics there was only one mention of infamous conduct and this was in relation to advertising.

Professional signs should be dignified and professionally restrained. Failure to observe these requirements could result in charges of 'infamous conduct' (Code of Ethics 1995).

In 1997, the Disciplinary Committees of Boards representing all of the professions supplementary to medicine met on five occasions to make a judgement on those about whom a complaint had been made. It is striking how few instances were brought to the Disciplinary Committees and that there was only one account of incompetence from 375,833 registrants; a radiographer had X-rayed a patient without providing a radio-translucent gown (Council for the Professions Supplementary to Medicine Annual Report 1996-1997). Whether this is due to the moral veracity of members or a weakness of the Professions Supplementary to Medicine Act (Ministry of Health 1960) is debatable. Certainly one of the flaws highlighted in the review of the Act was the inability to discipline misconduct falling short of 'infamous' (Department of Health 1996).

Its replacement, the Health Professions Act (Department of Health 1999), has greater disciplinary powers. The Health Professions Council (HPC) has set up an Investigating Committee, a Conduct and Competence Committee and a Health Committee whose roles concern the conduct, competence and fitness to practise of all registrants. Re-registration is now dependent on individuals undertaking continued professional development as proof of competence (Health Professions Council 2002). The HPC has also published documents on standards of proficiency for occupational therapists and standards of conduct, performance and ethics, which registrants must confirm that they have read. The term 'infamous conduct' has been removed although one of the duties expected of registrants is that,

You must make sure that your behaviour does not damage your profession's reputation (Health Professions Council 2003).

Furthermore, the powers of the HPC have been extended so that registrants can not only be struck off but also suspended, have restrictions imposed on their work or be publicly cautioned (Health Professions Council 2003). At the same time, reference to 'infamous conduct' has been removed from the latest edition of the code of ethics published by COT, which now has much more emphasis on the maintenance of professional competence. For example, section five of the present code states that,

Occupational therapists shall be personally responsible for actively maintaining and developing their personal professional competence, and shall base service delivery on accurate and current information in the interests of high quality care (College of Occupational Therapists 2000).

In 2003-2004 a 74% increase in the numbers of allegations received by the HPC was reported. There were 21 sanctions imposed: five against occupational therapists. Two were struck off for an inappropriate relationship with a patient and unprofessional behaviour, one was suspended for one year for a drink/drive conviction, and two were cautioned for two years for incompetence and working for another employer whilst on sick leave (Health Professions Council 2004). The intent to regulate the profession more realistically is evident. Hagedorn (1995) thought that it was important for practitioners not only to act ethically but also to be seen to do so. In this respect the code of ethics has become a symbol that occupational therapists can be trusted to be competent, to be disciplined and to behave with morality for the best interests of patients.

In order to understand the practitioners' perception of the code of ethics: whether or not it actually influenced their behaviour, what purpose it served and so on, they were asked the following questions:

- Every two or three years a new code of ethics is published... I have one here... have you glanced at it recently?
- What is the place of ethics in your day to day work?
- What do you think would happen if we didn't have a code?
- What do you think would happen if we didn't have COT?
- Does it alter someone's standing if they are not a member of COT?

THE VIEWPOINT OF PRACTITIONERS

Frequency of the Code of Ethics being read

At first glance it appeared that a formal code of ethics would be nothing more than window dressing for this group of occupational therapists; being scarcely

looked at by most. Eighty percent of the group admitted to rarely reading it. This widespread view is reflected in the following quotes.

OT25 (community): Well, to be quite honest I've probably not looked at it since I qualified.

OT30 (mental health): No... I have to admit. It's something you dig out if you're doing a talk and you want to refer to it.

OT5 (physical): We've got it stuck up on the office wall, don't ask me to read it.

The Place of Ethics in Day to Day Work

Given that most people read the code infrequently, practitioners were asked what they considered to be the place of ethics in their day to day work. Fourteen percent found it difficult to articulate the role of ethics to their daily work. They tended to quote one or two items remembered from the code such as confidentiality, avoidance of cruelty, or advocacy. However, as in this extract, they were all junior staff and this perhaps reflected their lack of experience of putting ethical knowledge into practice.

OT25 (community): Erm confidentiality [chuckle] sorry to keep harping on about that but yes that was and erm ... you've stumped me today! [Laughter]... it's a hard one I'm stumped... patients' rights that was another thing that we talked on, patients' rights and how, you know, they can sort of comply or not comply erm they have to be in agreement.

Closer scrutiny of the data was revealing. Forty four percent of the group linked ethics with 'behaving professionally'. This was a typical view.

OT27 (mental health): You're behaving in a responsible, professional manner with the client and er setting your treatment accordingly. And I think it should be a personal... er feelings about what you're doing is right and you're doing your best in your professional role for that client group or person... those kind of things.

Thirty nine percent considered that ethical behaviour had been instilled throughout their lives, for example,

OT13 (community): I think it's something that you maybe get the idea... You say... from... just professional people in general, just teachers at school. You get an idea of what professionalism is all through your life I think, through... dealing with professionals, seeing them on the television, seeing how a doctor behaves on the telly even if it's only fictional... things like that... I mean obviously you go through the code of ethics and things and obviously there's... there's things you're taught at school

which is like professionalism. You need this when you get a job you need to be punctual and you know you need to dress appropriately and a lot of those skills are actually taught at school I think... the basic ones.

Thirty three percent thought that ethical behaviour was so instilled that it had become subconscious. The practitioners shared the view that it was 'common sense' or part of their personality, a view expressed in the following quote.

OT19 (physical): I think there are a certain type of people... person that does train to be an OT or a health professional generally erm and I think that it's probably therefore far easier to take on board erm... parts of the ethical... I think some of it's got to be learnt, it's not something that we all know and do all the time erm but I think there's something to do with health professionals generally, that have a tendency to that.

In brief, the ways in which ethics is relevant to practice varies. A small number of junior staff were unsure about the role that it played in professional life but almost half of the group considered that ethics acted as a behavioural restraint, which was equated with professionalism. Ethical behaviour had, for the most part, been embedded in the practitioners. According to Berger & Luckmann's (1966) explanation, secondary socialisation has occurred within this group, in which the members have internalised the idea that ethical conduct is a component of the world of the professional. The individuals' interpretation of professional behaviour has been formed by interaction with other professionals, the media, parents, relatives or tutors. When occupational therapists noted such things as reliability, confidentiality, honesty, treating people with dignity, and equality of service delivery, they pointed out to themselves that these actions had the characteristics of ethical and therefore professional behaviour.

For some, ethical conduct was ingrained to the extent that the content of the code had become 'common sense'. Partly this was due to the individuals' willingness to accept ethics as part of the professional image. Several mentioned that it was a characteristic of their nature that they would behave in an ethical manner regardless of the code and therefore its dictates were no hardship. Berger & Luckmann (1966) thought that, for socialisation to work, the individual must be prepared to commit fully to what they described as 'role-specific knowledge'. In this case the role is that of 'professional', requiring ethical knowledge. These practitioners have immersed themselves in the idea that ethical behaviour was something to be admired and respected in a professional person and their response was to try to emulate such behaviour. They therefore, had chosen to behave ethically, so was a formal code actually necessary?

The Function of the Code of Ethics

Nineteen percent of practitioners (mostly people in senior positions) reported that they used the code for the function of informal policing to ensure competence. It

provided documentary support when dealing with staff problems. For example, this respondent used it as a tool to implement collective and internal control, keeping the behaviour of junior staff in check.

OT8 (physical): There are times when you think 'gosh I think that one's slipping a little bit'. And you pull it back and they say 'well nobody told me that' and you say '**it's in your code of conduct...** read it, you should have it at home'... so yeah it's a... I suppose sometimes, it's an area to back up issues that you might suspect or, just query... I don't think there's really scary things going on... but it's things like relationships with patients I don't think a lot of people... you know understand that or deal with it but it does happen.

Interestingly, the code became important for this respondent, working in isolation. Perhaps because of the lack of internal control mechanisms from colleagues the more formalised, written rules took greater precedence.

OT10 (community): Because of the nature of the work and because as OT's we're very isolated here and I think... we did have one OT before we came to here... I mentioned earlier we didn't but we did have one OT, a senior 1, and didn't last very long because of the professional isolation... So I use that to remind me... of my guide lines I suppose and that's why it's in my bag now more than *ever* before because I've always... before I've always worked in a team of OT's and now I'm in a generic team.

In research about whether or not professionals uphold the tenets of ethical codes, Hall (1975) argued that doctors, for example, failed to treat patients fairly. Yet, as this extract shows, these occupational therapists were at least conscious of the way they were expected to behave in this respect.

OT27 (mental health): I think it's treating people fairly and I think it's putting your own personal prejudices aside to deal with the client group that you deal with in a fair way and you treat one person as equally as another. You treat people the same, you're not... depriving them of treatment because you don't like the look of them or whatever... there's that kind of thing but also you're doing as much as you can for that client within your remit and what you're allowed to do.

Among the practitioners 47% quoted specific examples, demonstrating how individuals' interpreted actions that required an ethical response. On occasions the ethical code guided practitioners to behave with advocacy and a sense of beneficence. This practitioner secured re-housing for a patient after it had at first been refused.

OT17 (community OT): I've had cases refused by Housing and my manager and I took two of them through them and by finding out the legislation and finding out the policies I explained to them 'I still think you can help' and they have... but you do need that armory.

Another practitioner responded to, what was perceived as, unequal service provision for private patients.

OT1 (physical): In terms of our patients being sent to private hospitals and you know then getting an unequal service from an occupational therapist. In terms of we actually... go out and deliver them raised toilet seats but they're not actually getting an equitable service to... actually patients who are treated here with easy access so I've used it [the code] in that.

For this practitioner, with shared responsibility for the admission of psychiatric patients to hospital, the safety of the patient was of prime importance even if it compromised personal standing.

OT35 (mental health): ...Admissions... I always have no problem erring on the side of caution... to be laughed at the following day and told this a wholly inappropriate admission... I haven't got a problem with that... I'd certainly rather do that than... go home worrying about it... Waiting for somebody to commit suicide because I wouldn't send them in... so I would err on the side of caution and believe that's more professionally appropriate than... than leave the office unsure... and for home visits... how much risk do you sit on before pressing the alarm bells?

The practitioners reported that it was not always easy to uphold ethics in practice. They noted lack of objectivity in case note entries, for example.

OT36 (physical): Sometimes you see things written in notes and you think well... 'Wife looks younger than husband' and you think is this relevant?

Confidentiality was an aspiration but not one that was always easy to maintain. The difficulties could be quite prosaic, the result of an oversight or a therapist being hurried. On the other hand some mental health workers had experience of patients asking for their confidentiality to be respected whilst indicating that they were intending to commit suicide. This practitioner dealt with this by indicating that it was a circumstance where confidentiality would be breached, saying to the patient,

OT35 (mental health): You **know** we work as a team.

Consent to treatment often required reflection and adjustment and was riddled with ethical and legal considerations for this practitioner.

OT9 (physical): Like the whole consent thing, consent to treatment... It's very tricky I mean you try hard... I try hard not to enforce my beliefs or views on clients. I mean... several times I've seen clients who've got... cognitive problems say and there's so much you could do with them. And you could get them so much more independent but if they don't want the treatment then... they don't want it and who are you to say 'well you could live your life like this'. Because if they're happy then you have to leave it but... it's tricky because the... the divide between... So much now, there's so much legal issues going on... that if you've not got it documented, that if you offered this that and the other and they had an accident in the kitchen and 'why didn't they have this and why didn't they have that?' And you say 'they didn't want it' you really have to be careful.

For the practitioners, one of the functions of a code of ethics was to enforce collective censure. Tawney (1921) was one of the first writers to highlight the importance of collegiality for the professions. Moore (1970) noted that when professionals worked with colleagues, the knowledge that others were watching acted as an efficient form of internal control on the behaviour of individuals. Hughes (1981) thought that colleague-ship and professional ethics were closely linked in that codes of conduct placed people in roles where the rules of behaviour were clearly defined. Colleagues were able to recognise who had permission to be included in the group and who should be excluded: such exclusivity having connotations of status and respectability (Hughes 1981). Johnson (1972) was also interested in collegiate control within professionalism, although in his analysis, the purpose was to secure power through autonomy. In this case, collegiality as a form of internal control was evident among the practitioners but for reasons of maintaining competence, rather than power.

Moore (1970) thought that, without enforcement, professional codes could be little more than window dressing and there was little evidence that they had any real influence on actual behaviour. It might simply be the case that some individuals were naturally more interested in standards of competence than others. Wilding (1982) also questioned the tendency for ethical codes to be accepted at face value. These authors considered codes of ethics to be primarily, organisational tools used to secure autonomy and monopoly, particularly, as far as Berlant (1975) was concerned, in respect to medicine. This was not the case for the practitioners, who provided many examples of ethical decision making in practice. Whilst it was true that they had an inherent inclination towards it, personal reflection of ethical behaviour was revealed to be dynamic and as such, evolved as new situations were encountered. Checks and adjustments were constantly being made. Senior staff members helped to perpetuate ethical performance on a day to day basis. In a real sense, the code of ethics did influence the behaviour of these practitioners. It made them aware of what was expected of them and drove them to put the patient's interests first. The fact that

they sometimes found it difficult to follow the code to the letter is testimony to the idea that they were paying more than lip service to it.

Regardless of the fact that the code was rarely read, practitioners still behaved ethically and many reported that they considered themselves to have an ethical component in their character. They were therefore asked to consider the consequences of not having a written code of ethics. For 83% of the group, a written code was most useful, as a tool to demonstrate the discipline required of occupational therapists, which could and would be enforced, when necessary. The following quote is characteristic of this view.

OT31 (community): I guess the place where the COT code of ethics would come in is if you've got something that is rapidly coming towards litigation and you're immediately reaching out for the code of ethics because you just *assume* that day to day... that, that's what you're working by... That whatever you do is, you know, done in good faith and is done within that sort of framework.

Because of the status and identity it attracts, a further strand to the symbol of profession is the idea that high standards of behaviour are necessary, according to Elliott (1972). He considered that when people were totally immersed in their professional identity and status they were more aware of the need to adopt a particular life-style. In many ways this echoed the work of Tawney (1921) and Durkheim (1957) who argued that a strong, collective morality both at work and at home was necessary to give the professional world greater authority over that of business. Johnson (1972) thought that by demanding strict adherence to rules of conduct for all members of the professional group 'occupational homogeneity' was created, the result being that the rules were observed both in and outside of the workplace to avoid risk to the professional, authoritative, image. Nineteen percent of practitioners thought that the existence of a code was an important symbol of professionalism. They were happy to accept the stringent discipline of the code of ethics and encourage others to do the same, not because it gave them authority but because it entitled them to adopt the associated status and imbued them with a sense of pride. This extract sums up the general view.

OT10 (community): I would say of **all** the professions that OT has... of the highest standards... Which makes me very proud... So I suppose actually what I'm saying is that yes people would continue to have those high standards and I think a lot of the onus is put on a) responsibility but b) training as well. And also the working environment and we all have supervisors and line managers and it's... it's our responsibility to make sure that the person we're supervising adheres to certain... professional standards.

This practitioner reflected the perception of the majority, who accepted the requirement to modify behaviour both in and outside of work.

OT3 (community): I *know*... that there's a certain standard... of appropriateness and professionalism that needs to be maintained erm... personally and within the work itself.

In summary, the practitioners reported the main function of the code of ethics to be that of public symbol. Some thought that high standards of behaviour were a necessity, which entitled them to professional status, which gave them pride. Hagedorn (1995) thought that the idea of professional ethics crossing over into an individual's personal life was something of a 'polite fiction'; nevertheless this group accepted the need to modify behaviour both in their personal and working lives. Being aware that the public was likely to view a code of ethics as an attribute of professionalism, they were prepared to act as it dictated. Even though they had a natural inclination towards honourable behaviour, the code of ethics provided a symbol for these practitioners, giving a clear and public indication of the discipline and circumspection required. The code has the same meaning for the public and occupational therapists; the former expects a certain type of behaviour, the latter are happy to respond appropriately and everybody is clear. The effect is to invest it with authority, making it more likely that individuals would perform within accepted guidelines (Goffman 1969).

The College of Occupational Therapists (COT) is responsible for writing the code of ethics. Since it is considered essential, the practitioners were asked to consider the consequences of not having a professional body and therefore no means by which to publish a code.

The Role of the College of Occupational Therapists

Ninety two percent of the practitioners considered COT to have a vital role as a symbolic head of a unified profession. The functions that they attributed to it were largely protectionist and included co-ordination of activities, organisation of research, control of education, official representation to the public and state and advancement of occupational therapy. The following view was typical of those expressed.

OT34 (mental health): Every profession needs a base or... a body that they know is there even though they might never use them, you know. It's quite... secure to know that they're a body there that... that are promoting the profession and are fighting, you know, are... helping us to... develop.

Many practitioners did not make use of the services offered by COT but considered its existence to be important, a view expressed in this quote.

OT36 (physical): Well I've never had much to do with them [laughter] but yes I think we need them there to... I mean I think things are happening that are better, there's much better journals now, they've really improved

over the last few years... and I think we *do* need somebody up there... saying to government this is what we need, what we don't need.

Some considered that COT functioned at a symbolic level but did not have a direct influence on day to day experience of an occupational therapist. This was the case for this practitioner.

OT34 (mental health): I feel very alienated in a way from [COT]... and I don't know how that can be... remedied... sometimes I think... it's important to have them there erm... but you feel... they don't know exactly what I do.

This practitioner expressed frustration that, despite political changes, which could have been advantageous for community based staff, the professional body had little input in establishing where occupational therapists would be most effective.

OT2 (community): I mean at the moment in theory we should be on an up... from the point of view that... the vast majority of services are moving to community... that's where we function best as far as I'm concerned erm... I don't think we function incredibly effectively in a hospital setting ... particularly on a functional assessment basis erm... I think we waste a lot of time doing false assessments.

For the majority, although it was in the background, the most important feature of COT was that of a symbol representing occupational therapy to the public and government as worthy of professional status. However, in answer to the question 'does it alter someone's standing if he/she is not a member of COT?' 80% said that it did not. This was curious given the way that they perceived the code of ethics and that they considered COT to be symbolic of professional status. The following quote demonstrates the characteristic view that it was more important to focus on practitioners' performance, rather than membership of COT.

OT25 (community): I think because I know a few people that aren't members and they're very, very good OT's it wouldn't make that difference to me.

This practitioner represents the view of several that did not believe COT offered value for money.

OT5 (physical): I think it's awfully expensive now for what it is now... I mean I know things have gone up and up and up but really we don't get a... fair return for it do we?

Many reported that, whilst it would not alter someone's standing, they thought membership of COT was important and that they would encourage others to join. As the following quote illustrates, the main perceived benefit was indemnity insurance against litigation.

OT16 (mental health): Everybody I know joined... for the insurance [chuckle] and the protection that that gives because it was easier than sorting it out yourself... I don't actually know anybody who isn't a member.

Eight percent were not sure whether or not it mattered but assumed that most of their colleagues were members, again for the indemnity insurance, a point made by this practitioner.

OT36 (physical): I've never given it a thought. I don't think I've met anybody that's not really... I know our manager here has always encouraged everyone to belong... I think mostly for insurance purposes.

Only 11% were prepared to say that it *did* alter someone's standing if that person was not a member of COT. As suggested in the following quote, these practitioners thought that membership was a reflection of professionalism.

OT10 (community): I would be curious to know why... they weren't a member and I suppose I'd do my PR bit to encourage them to be a member. I would like to think also that I take people on their merit but I suppose my initial reaction, my gut reaction would be that yes you do, we do that. It's expected that we do that. I haven't challenged it which is unusual... but yeah I think if we want to call ourselves professionals then there are certain things that have to go along with that and yes I would naturally assume that that was one of the things.

In summary, most practitioners thought that COT was a symbolic head protecting the interests of the profession, even though some made little use of the services offered and its influence at grass root level was small. Non-membership of COT was not considered detrimental to personal standing. Nevertheless, most occupational therapists are in fact members of COT (British Association of Occupational Therapists 2001-2002; Council for the Professions Supplementary to Medicine 2002) so why this reaction? One of the explanations may be that the practitioners may not have wanted to judge a peer negatively. That would be consistent with way that character screening and failing students was difficult for them. On the other hand, some considered that membership was prohibitively expensive and it was apparent that most people had joined for the indemnity insurance. It was this that compelled practitioners to become members of COT, rather than an increase in standing it might confer on individuals.

Traditionally, disciplinary bodies have imposed authority over professionals by active enforcement of the codes of ethics (Millerson 1964a; Becker 1977). In the case of occupational therapy, it is the Health Professions Council, that performs the disciplinary function and whilst it has set its own Standards of Conduct, the College of Occupational Therapists writes, what most would perceive to be *the* code of ethics. This is not legally binding but it does have influence when disciplinary procedures are brought into play. These respondents viewed the

function of COT as protecting the interests of the profession and of individuals through indemnity insurance but did not associate it with the enforcement of the codes of ethics. Only two respondents mentioned that without the professional body the code would not have been written. Only three referred to COT members being role models for the reinforcement of ethical standards. Perhaps it is fortunate that these respondents were intrinsically ethical because from the practitioners' perspective, COT had little influence. Whilst Millerson (1964b) claimed that qualifying associations were symbols of professional status because they demanded conformity to behavioural norms, the practitioners thought that any influence from COT on their beliefs about ethics was relatively weak. Giddens (1983) argued that one of the functions of professional associations was to establish ethical standards of behaviour as the prerogative of the professions. It may be that COT has not brought this home enough but of course the COT respondents may have a different perspective. This will be addressed now.

THE VIEWPOINT OF the COLLEGE of OCCUPATIONAL THERAPISTS

The Function of the Code of Ethics

All of the respondents regarded the code of ethics as a public and personal reference outlining the standards of behaviour expected of occupational therapists. This was a typical comment.

COT5: I think it is good to... have... a reference guide, which actually does promote... a good or recommended standard erm. But one provides an OT with clarity about erm about how to behave in that sense but also informs other people... a little bit about the regulations or the erm recommendations erm that OT's are required to adhere to.

This respondent was aware that individuals seldom read the code and thought that it had little influence on behaviour but was probably used as a disciplinary tool in times of crisis.

COT1: I'm not sure how much it impacts on people... or... is it something you use as a reference when you need it if you're dealing with a sort of critical incident or unfortunate circumstances or you or you're presenting a case of need for extra resources or... something?

Another respondent referred to it as an instrument that could be used to the advantage of the profession.

COT5: We also use it as a lobbying tool as well, which can be useful. I'm talking about influencing governments, influencing different agencies, we can refer to that source of information.

Two respondents thought that the existence of a code enhanced the image of the profession, particularly, as far as this one was concerned, through highlighting a moral dimension.

COT6: It is important in terms of image to say that we are developed enough, we know enough and we care enough to be able to say there are a few things... which are actually central and... Clear moral judgements about our profession and clear ways in which we do things. That we can state to other people and people understand and people know... I don't think you can be a profession without that.

Two respondents referred to the fact that the COT code is voluntary and it was the statutory body that had the real disciplinary power, a point made in the following quote.

COT1: I think if you're thinking in terms of discipline then it really is not the professional... it's what the statutory body... the Occupational

Therapists Board highlights as erm gross misconduct and their statement of misconduct that is more the... power.

One respondent was sceptical about how much importance was placed on the content of the code, by those who wrote it.

COT2: Well we keep quoting it left right and centre... It always feels a bit vacuous when we keep quoting the research bits... the last code of ethics was 1995 they are reviewing it as you're probably aware at the moment and we... change it a bit with the research bit but I suppose I still think so what?

This respondent thought that it was more important that individuals learned ethical behaviour through socialisation.

COT1: I think that... for me that's the whole process of professional socialisation that is like the hidden curriculum that people learn... particularly when they're on placement...erm... and I suppose that's to me more what that's about.

COT members considered the code of ethics to be a formal declaration of the conduct required of occupational therapists. It was essential to the professional image and could be used in negotiations with influential agencies. However, there was no power of enforcement and its capacity to influence individuals' behaviour was in doubt, although it could be useful in disciplinary procedures. The socialisation process was perceived as having greater influence on ethical conduct. Nevertheless the code of ethics is closely associated with COT so what influence did these members believe the professional body had on practitioners?

Membership of the College of Occupational Therapists

It is not surprising that all of the respondents considered membership of COT essential for all occupational therapists. Characteristically, as this extract demonstrates, they were concerned about the professional behaviour of non-members.

COT7: I have very strong views about people who are not members! [laughter] I feel very concerned about people who can call themselves occupational therapists who... are not members of their professional body... Which means... they... therefore I suspect are not... bound by the code of ethics, they don't read up to date research, they're not reading their journal, they're not keeping themselves professionally aware or competent in their knowledge base. They're not aware of issues that are going on, where people have been... erm struck off or challenged on the grounds of ethics. And I think it really calls into question... how people

can be... how people can think of themselves as a professional person... if they don't make a commitment to their professional organisation.

It was important to COT that its members were seen to be competent, honourable and of good standing. At the time of the interviews it was possible for an individual to be struck off the state register but have their name retained on the membership list of COT. This loophole has now been closed but was a cause for concern, at that time, for this respondent.

COT3: There is for instance at the current time an OT who has been struck off the CPSM register... who is still on our register. Now I would say that this will be somebody who... we would not want to be on our register... which we would want to remove... And we really need to er... formalise a procedure to put into operation or to... how to remove this person from the register it is in our articles that we should have members of good standing.

There was an understanding of some of the reasons for people not maintaining their membership of COT. For this respondent it was a matter of concern.

COT6: It worries me that there's a... there's a section of the profession who... for whatever reason whether it be cost or whether it be difference of a value base or whatever... doesn't see those things as being ... critical or important... to them. And I think all the while those people... exist we have some cause to worry.

Some recognised that efforts from COT to be seen as relevant to its members had not always been successful. According to this respondent, it had been partly addressed because individuals were given the opportunity to join a specialist section without becoming a full member.

COT7: I can see why... the profession's not maybe... Things always work two ways... and not maybe... encouraged people to feel part of their professional body... and that concerns me... But we also have the specialist section groups who are providing... what could be seen as professional services because not all their members... are members of COT/BAOT so... in fact sometimes it's a quarter of their membership are not members.

The Ethics Committee, a branch of COT comprising occupational therapists and legal representatives, is responsible for producing the code. In this respondent's opinion, however, although it has recently been reviewed, this did not extend as far as was originally intended and it had not been possible to involve individual members.

COT1: The Ethics Committee meets regularly and there is a review going on at the moment erm. I think it'll be re-published again this year...erm... At one stage the Ethics Committee... this is also part of the problem the ethic... the previous chair of the Ethics Committee who'd erm... led the latest version is wanting a review and feedback nation wide. But I don't think that... I think that was found to be too costly so I think there's been a much more internal and limited review er... again to up date it I think rather than do a radical revision.

Individuals who are not members of COT do not receive a personal copy of the code of ethics. This was not seen as problematic, firstly because, as professionals, they would be expected to take responsibility themselves for receiving a copy of the code, either by accessing a departmental copy or purchasing one from COT. Secondly, practitioners would be expected to behave to the necessary standards regardless of whether or not they had read the code. They would also be bound by the more powerful standards documentation, published by the statutory body, a point made in the following quote.

COT1: I think, I think the first point is how much is it used in that context anyway erm...? People who are not members of the profession... professional body but are still state registered would still be assumed to work to the code of conduct erm the statement of conduct issued by the erm... Occupational Therapists Board and that also refers to the code of conduct.

Thirdly, for this respondent, there was doubt regarding the affect the code had on the behaviour of individuals.

COT1: I suppose my question would be does it influence what people do anyway?

These respondents saw one of their roles to be co-ordination of the regulation of occupational therapists. They were concerned about standards but were lukewarm about their ability to instil ethical behaviour in members. The review of the code of ethics was not given a high priority and they placed much of the responsibility for the monitoring of conduct on the CPSM and onto individuals themselves. These COT members therefore, have viewed the code of ethics as more of a symbolic tool for the public domain than as something that has purposeful implications for every day practice.

This is not surprising for the organisational body but the educators, charged with the task of instilling ethical behaviour in future occupational therapists, were likely to have a different perspective.

THE VIEWPOINT OF EDUCATORS

The Function of the Code of Ethics

Some of the respondents bore witness to the fact that most practitioners failed to read the code of ethics. This comment was typical.

T1: ...Does anybody read the code of ethics [laughter]...? Students get the code of ethics ... but do they ever look at it again em ... to be quite honest? ... I think you have a set of standards for yourself and I think every individual differs ... em... I think then when people get into trouble the code of code of ethics is brought forward as the policy thing and this is what we should be doing.

However, they all agreed that the code itself was a symbolic, disciplinary tool both for the public and practitioners. For example,

T4: Well it's like a er... safeguard... perhaps...(2)... for the public... uh...(2)... which has clearly... clearly set out...(1)... from the College of OT... There is the... expectation that everybody knows about it...(2)... from a student... point... uh... and we also... know the consequences... if we don't meet it...(1)... and I think in that sense it's a safeguard to the public.

But more important was the notion that ethical constructs should be inculcated, during education, through the socialisation process. This often began at an early stage, as this educator explained.

T3: Their first... essay... in the first module... is... based... on the code of ethics... and professional conduct... so I little bit... ram it... down their throats.

This extract gives a picture of the ways in which certain mores are instilled. Interestingly, the respondent made the distinction between 'training' rather than education as the route through which such knowledge was transmitted.

T1: I think we try and teach... we certainly have ethics as part of our course... and I think it's... you know we... we really do stress... em things that are important. Like good note-keeping... good relationships with colleagues and patients... anti discrimination... use of [foul] language... and... things like that. So I think ... you know... if you're going to look at ethical... approaches that has to be an integral part so that you... As... somebody who's going through their training... you know... it... it is still... training to a certain degree as well as education and there is a kind of a... certain moulding process that goes... through. ... Em... you know it is about... as an educator you are... influencing...(1)... students development not just through their academic work but how you

behave... The opinions ... that you... express... em... and students do take staff... and... er fieldwork educators as role models.

This respondent emphasised the ways in which altruism was stressed.

T2: Putting yourself second... the client... putting the client... I mean in our case... it's the student... first... and ourselves second.

The following quote suggests that discipline about keeping the code in people's minds should be encouraged.

T2: Maybe you know at appraisal... you should say... that you have... you should say... that you have... you should say that you have read through the code of ethics since your previous appraisal... little checks and balances like that can be put in... yes.

Membership of the College of Occupational Therapists

Membership of COT was encouraged for students once they became practitioners. For this respondent it was necessary for keeping up to date but also for insurance purposes.

T3: I think we should be encouraging people... who are practising out there... to be members of the College of OT...(2)... And it does worry me...(1)... people who practice who aren't...(2)... because... all the things about... keeping up to date... keeping in touch...(3)... insurance cover...(1)... all of those things...(2)... I think it's vitally important...(1)... that they are members.

Yet, some educators were not members of COT. This respondent believed that they would receive better employment rights from bodies established for higher education institutes.

T1: Not every member of [the] education staff are members of COT...(2)... I...(2)... well I think it is a cause of concern... but ... whose concern is it...? I think COT has to recognise that... if you're working out of the NHS system... you are... usually paying considerable amounts of money to other professional... organisations... which will support you... in the environment in which you're working.

Therefore it became a clear choice.

T1: It comes down to... who do you want to be a member of... your professional body...(1)... or... do you want to protect your employment rights?

The educators assumed that the code had importance as a public symbol, indicating the trustworthiness and competence of practitioners but that its influence on the behaviour of individuals was negligible. They fully accepted their role in the socialisation of students into the cultural requirements of ethics. It was seen as something specific to professionalism, distinct from other aspects of education. Membership of COT was considered important for practitioners, partly for the protection against litigation but not for educators, since it did not serve their needs.

Finally, what was the stance of the Council for Professions Supplementary to Medicine (CPSM)?

THE VIEWPOINT OF the COUNCIL for the PROFESSIONS SUPPLEMENTARY to MEDICINE

The Function of the Code of Ethics

All of the respondents made the distinction between the Statement of Conduct, produced by the statutory body, which is legally binding and the code of ethics written by the professional body. This respondent, particularly, noted that a practitioner could not be disciplined for a breach of the COT code of ethics.

CPSM3: The statement of conduct is backed by statute and will be via the new legislation whereas of course the code of ethics is not. And therefore if you fall foul of the code of ethics nobody can do anything about it but if you fall foul of the statement of conduct you can be struck off... If you're brought through the disciplinary procedures er... therefore it is binding.

However, the code of ethics had an important role as reference material, as this respondent explained.

CPSM1: It underpins... a number of other things, some of which have... legal force... For example definition of a scope of practice... Whether an activity is occupational therapy or not is often judged by cross-reference to the code of ethics... Equally it may underpin... procedures that come within remit of the Whitley Council Industrial Relations Agreements... which again can have statutory force in some contexts so although it's not itself a statutory document it underpins a number of other statutory activities.

This respondent, with years of experience had noted different orientations to the various codes. The inference was that professions such as occupational therapy and physiotherapy had codes that were service driven.

CPSM3: I... rather get the impression there's a difference in emphasis... erm I have read the code of ethics for the radiographers... the Society of Radiographers... it has a different slant... from the... from that of the... occupational therapists. I've not read the one for...er... physiotherapists erm for some time, I did read it three or four years ago but I've not read it for some time... They're basically the same but they... each professional body has... is coming from a different direction... The erm Society of Radiographers has strong roots in the trade union movement... very strong roots in the trade union movement and very much it sees itself... as well as being the professional body... as being a trade union.

Membership of the College of Occupational Therapists

To an extent, whether or not an individual was a member of the professional body, was not a concern for CPSM, although this respondent was derisive of non-members.

CPSM2: I think they're poor professionals.

On the other hand, this extract reflects the view that membership of the professional body was a symbolic indication that an individual was acquiescent to the way in which the profession was organised, would be compliant to the code of ethics and was adequately insured.

CPSM3: Well that's entirely a matter for the College we can't do anything about that and... and I think on the whole... [House of] Lord's would... hope that... their registrants would join the professional body for a variety of reasons. Partly because it is the... organised profession in the way of the Board erm... therefore it should be involved in the development of the profession. And that they should er good practice that the code provides and also that they... from the point of view of their clients and patients they have... adequate professional indemnity, which most of the professional bodies provide.

Although the COT code of ethics has no legal power, the CPSM respondents considered it to be a useful reference tool. They thought it probable that there was a service orientation to the code, rather than having a direction that would be favourable to the profession. Membership of COT, although not necessary for registration, was perceived as a public indication that the profession was organised and disciplined; that practitioners were willing to abide by rules of conduct and have their behaviour monitored. Once again the availability of indemnity insurance was emphasised.

SUMMARY AND DISCUSSION

In summary, as Goode (1969) intimated, occupational therapy is an example of a service profession with an explicit code of ethics. Whilst the formal code was rarely looked at, practitioners had accepted Wilding's (1982) contention that the code was a guarantee of moral veracity, the ideal of service and colleague control. Ethical behaviour was synonymous with professionalism and had become ingrained into the psyche of most people. It had been internalised as a result of interactions with family, friends, other professionals, the media and through the education process. The ease with which this was done could, in part, be attributed to the individual's willingness to commit to ethical behaviour. Having learned in childhood that ethics was a virtue it was not difficult to transfer the same virtue to their professional world and it gave them a sense of pride. This highlights the importance of screening candidates for their attitude to ethics prior to entry to education. From the COT perspective, COT publishes the code, and ethical issues

are given coverage in the British Journal of Occupational Therapy, but the perpetration of ethical values amongst members was left largely to others. The educators, on the other hand, took their role in the socialisation of ethical values seriously. Altruism was emphasised and ethical behaviour was regarded as something that required constant internal and external monitoring.

As far as the practitioners were concerned, one of the functions of the code of ethics was as an instrument of colleague control. It provided a set of rules by which everyone expected to be governed. Colleague control has been criticised as ineffective and it might be anticipated that the practitioners would be unwilling to formally discipline colleagues, given their reluctance to fail students or otherwise judge people. In this sense the code could be considered a weak governance mechanism. On the other hand, they actively checked their own and each other's behaviour on a day to day basis and, from this point of view, it was working effectively.

The capacity of a code of ethics to influence the behaviour of individuals has been questioned. The practitioners knew, on a cognitive level, what types of behaviour were expected but they also gave examples to demonstrate their ethics in practice. They conformed to their role and engaged in a disciplined performance. Seniors reminded juniors of their ethical obligations. They strove for objectivity in documentation, confidentiality, honesty, unconditional regard, and informed consent to treatment. They tried to act as advocates for patients and to ensure equitable service provision. The fact that they sometimes had difficulty adhering to ethical directives and often had to weigh up ethics against legal issues demonstrates that it was a dynamic and real part of their world. This is testimony to the fact that the code of ethics was influencing their behaviour. In contrast, some COT representatives noted the lack of power that the code had and doubted its effect on behaviour.

Despite the fact that the practitioners considered themselves to be ethical by nature, the majority thought that a formal code was still necessary as a public declaration of trustworthiness and honour, a view that was shared by the educators. It was especially important to have an authoritative code in this modern, litigious society. It also served to provide status and a sense of pride because it enforced the idea that practitioners belonged to a privileged group and that being a professional was so important that it necessitated the highest standards of behaviour both at work and outside it. They did not therefore, look at a code of ethics from an organisational or monopolising perspective but as a form of self-regulation in the positive sense of protecting patients. The CPSM representatives agreed; they had the impression that the code reflected concern for patients rather than protection of professional interests.

Since it is the statutory body that disciplines registrants and protects the public it is reasonable to expect that COT would direct its interests more towards professional advancement. The code of ethics, from their perspective, was valued

as a symbol, which enhanced a professional image, could be used as a lever in national level negotiations and at local level for managers to use as a disciplinary marker. The COT representatives reported that the last review of the code of ethics was not given the seriousness it deserved and was conducted internally because financial restraints prevented the membership becoming fully involved. Non-members of COT, who did not automatically receive a copy of the code, were left to their own devices. The fact that those individuals were referred to the more authoritative Standards of Conduct, published by the HPC, suggests that the code of ethics was viewed as a back-up rather than a stand alone document, especially when the comments about the code not influencing behaviour are taken into account. The CPSM respondents supported this view, highlighting the role of the COT code of ethics as something that could be used as an adjunct to the legally binding Statement of Conduct.

Almost the entire group of practitioners perceived COT to be the symbolic head of the profession. This was notwithstanding that many did not make use of its services or found it remote, with little influence. Most thought that being a member of COT did not entitle them to any status or privilege. Perhaps they were trying to demonstrate unconditional regard but some expressed the opinion that COT was not offering value for money. A very small percentage reported that non-membership was a cause for concern. The role of the COT was considered to be more protective of its members than of the public, being largely construed as a means to secure indemnity insurance. It was involved to a lesser extent in the reinforcement of an ethical construct: a code of ethics was perceived as powerful in this respect but COT was not. Some educators excluded themselves from COT because they did not think that it addressed their interests. They took the same view as the practitioners, there was no status attached and the main benefit of membership was protection against litigation. Educators can themselves be sued but they were more likely to be supported by the professional bodies of higher education. Membership of COT was not a matter of concern to CPSM but was considered to have a purpose as a public declaration of the profession being organised and of practitioners being protected against litigation. Although the COT representatives realised that cost and an image of being remote from practitioners was prohibitive, they all considered it essential that occupational therapists were members of their professional body. Their concern was to encourage ethical behaviour and to have symbolic structures in place, which would advertise members as being 'of good standing' but their role was a distant, organisational one.

Larson (1977) argued that because individuals can choose whether or not to join the professional body it has a weak effect on cohesiveness. Professional associations were often made up of the elite of the profession; in the case of occupational therapy they are not elected and, according to Larson, such people tend to steer the profession in a direction that may or may not find agreement with the (voluntary) membership. In this case, educators had chosen alternative professional bodies that offered more benefits. Since COT has formed an alliance

with UNISON practitioners have the opportunity to get indemnity insurance from the trade union rather than the professional body. They need a better reason to join COT. The practitioners and COT representatives had different perceptions of the code of ethics. There was a difference of opinion regarding the status that COT membership accords. These examples illustrate the ways in which COT was considered out of step with the membership and suggest that much could have been gained from including them in the review of the code of ethics.

The code of ethics was given less significance in the view of COT respondents because they assumed that ethical behaviour was learned through socialisation. This is partly true. Practitioners are driven towards ethical behaviour because of their own inclination, through the socialisation process and education, but the symbolism of the code of ethics carries an importance that should not be overlooked. It has several functions: it can be a guarantee of moral behaviour, a self-regulatory mechanism, and an organisational tool. It can influence behaviour and offers status. Effectively, it is an explicit representation of the tacit knowledge of occupational therapists with respect to ethical values. In essence it serves to shape the belief by society that occupational therapists can be trusted. One of the ways that the code can be expressed, in practice, is through a service ideal and it is to this that the next chapter will turn.

CHAPTER 8 – FINDINGS

Data showing the initial coding and categories for the service ideal are presented in Appendix 10.

SERVICE IDEAL

It has been assumed that a professional will always act in the best interests of the client, put self-interest aside and provide the highest standard of service (Johnson 1972; Becker 1977). This service ideal is central to the moral dimension of the professional symbol. Historically, it served as a counter to the ruthless business world (Horobin 1983). Before the 1930s, virtually all writers thought that professionalism offered a way of life morally superior to the market place (Haskell 1984). Altruism, dedication and expertise in the delivery of a service, which was vital to the wellbeing of humanity, all contributed to the ideal (Carr-Saunders & Wilson 1933; Hall 1975).

‘Vocation’ was closely linked with a service ideal, providing it with a religious association. At its most extreme the Florence Nightingale image epitomised the moral pinnacle that must be reached. Traditionally, for example, a nurse,

Must have quelled any desire to enjoy any life which might impinge upon her life as a nurse (Alavi & Cattoni 1995: p345).

It also conveys the idea that work can have intrinsic value. Finding fulfillment through work is a notion that stems from craftsmanship rather than business ideals. It was in contrast to the norm for the working classes during the industrial revolution, when any work no matter how unpleasant, was undertaken to avoid starvation, and therefore the value was extrinsic (Larson 1977).

Haskell (1984) agreed that until the early twentieth century, analysts (Parsons, Tawney, Durkheim and so on) saw the professions as a ‘promising corrective’ to the wild excesses and uninhibited competition of capitalism. Subsequently, attention has focussed on the idea that professionals are just as motivated by self-interest as any other group but the rewards are other forms of ‘self-aggrandizement’ (status and reputation, for example) and not financial. Non-pecuniary gains were considered preferable to greed but in return for their privileged position, professions were morally obliged to use their knowledge for the good of society (Larson 1977). In fact, Parsons (1939) realised this and argued that in business and professional work the aim was objective achievement and recognition. Professionals work and compete in a market where the currency is expertise. It is this that compels them to uphold high standards, to allow some to distinguish themselves above the rest and to rise in eminence (Haskell 1984).

Goode summarised four dimensions to the service ideal:

- The professional decides the client's needs, the consumer has no input.
- The practitioner who lives by the ideal of service has made sacrifices in terms of loss of earning during a long and arduous training.
- Society must believe that professionals follow the ideals.
- The professional community creates a system of rewards and punishments that makes 'virtue pay'. In return, individuals who follow the norms of the service ideal are rewarded with occupational success (Goode 1969).

The success of a service ideal was dependent on it being accepted as a normal part of society. Lukes (1974) proposed a three dimensional view of power, which involved shaping perceptions, knowledge and preferences in such a way that the public accepted their role in the existing order of things, either because they could imagine no alternative or because they saw it as natural or valued as beneficial. Ethics and the service ideal have been used in just this way to shape the belief by clients that it is natural to expect professionals to have probity and therefore they could be trusted. Even if it was mere rhetoric, the expectation of trustworthiness has become so ingrained that both professionals and clients have accepted it as the norm (Horobin 1983). On one hand, this was necessary to reassure the client that it was safe to divulge all facts, no matter how embarrassing, which would allow the professional to work successfully (Becker 1977). On the other hand, it was essential to secure a market (Larson 1977), power and privilege (Johnson 1972; Wilding 1982). In addition, exclusivity could be achieved through the proclamation that the market should favour those with a service ideal to protect the public from charlatans (Montague & Miller 1973).

The image of the selfless professional lingers on but modern reactions to it range from mild scepticism to outright dismissal (Horobin 1983; Haskell 1984). Larson (1977), Freidson (1994), and Wilding (1982) have all noted a lack of empirical evidence about the number of professionals who manifestly follow a service ideal. Johnson (1972) suggested that the ideal of altruism might not be a tangible fact for individual professionals. Wilding (1982) particularly challenged the altruism of professionals, citing the unwillingness of doctors to work in areas of greatest need and their participation in industrial disputes. He thought that, when professions became involved in industrial disputes, the perception by society was that they were using vulnerable clients as pawns in the struggle for improvement in their own position. Recently, hospital consultants threatened to work to rule over their objections to a proposed new contract. Whilst claiming their demands would produce better patient care their self-interest was clear. They asked for less management control over career structure, better recognition of evening and weekend working, and less arduous restrictions for junior consultants who wanted to do private work (Charter 2003).

Governments since the 1980s have questioned the motives behind professional actions such as protestations of a service ideal (Foster & Wilding 2000). Nixon

(2003) has reported that since Margaret Thatcher introduced market-driven policies, with a model of private sector managerial professionalism, society has lost sight of the public service ethic, which was problematic. Bennett & Hokenstad (1973) argued that the service ideal should remain a feature of the 'personal service' professions because it sits easily with an anthropological knowledge base (bringing about change in the client, transferring knowledge, to encourage enablement), which they advocated as a better alternative to science for such groups. Occupational therapy falls into this category of service profession, so to what extent does it use a service ideal?

THE SERVICE IDEAL FROM THE PERSPECTIVE OF OCCUPATIONAL THERAPY

The aspiration of a service ideal is implicit in the code of ethics for occupational therapists, which states that,

Occupational therapists shall at all times recognise, respect and uphold the autonomy of clients and their role in the therapeutic process including the need for client choice and the benefits of working in partnership. Occupational therapists shall promote the dignity, privacy and safety of all clients with whom they come into contact (College of Occupational Therapists 2000).

In the 1980s the profession became more political and militant. In 1985 some members participated in a public march, which was ostensibly protesting about cost cutting in the NHS but also used as a platform to demand greater numbers of occupational therapists (Wilcock 2002). Some professions have set up an organisation parallel to the professional body for trade union functions to avoid compromising the 'professional' stance (Johnson 1972). This has been the case for occupational therapists. The British Association of Occupational Therapists (BAOT) and the College of Occupational Therapists (COT) produce two publications, the British Journal of Occupational Therapy (BJOT) and Occupational Therapy News (OTN). In 1978 BAOT became a trades union, and matters related to salaries or conditions of service were published separately in OTN. In so doing, the charitable status of COT was not compromised. Professional matters continued to be reserved for BJOT. In 1993 an agreement was struck between BAOT and UNISON, which further strengthened trade union activity (Wilcock 2002).

Despite the increased politicisation the service ideal seems to have been a taken for granted assumption for occupational therapists and there has been little questioning of its tangibility. Sachs & Labovitz (1994) found that occupational therapists in their study considered the essence of professionalism was a commitment to responding to patients' needs. This sometimes involved tasks outside their role definition but they regarded it as appropriate in order to gain trust and cooperation. However, Jones & Stewart (1998), reflecting a general perception that the service ideal was little more than rhetoric, challenged occupational therapists to value a more equitable relationship with patients and to

consider whether their orientation was directed towards patient welfare or their own status. Whilst the official view is that a service ideal exists for occupational therapists, increased trade union activity may have altered individuals' perceptions and there is an underlying impression that they are moving towards greater self interest. In order to understand their views, about the service ideal, the practitioners in this study were asked the following questions based on the literature.

- I wonder whether or not you think occupational therapy is altruistic?
- What are the attractive fields of OT? Why is that? What are the unattractive fields? Why?
- There is always a shortage of OT's in the care of the elderly and competition for posts in neurology, for example. What do you think that says about the service that OT provides?
- When you are planning treatment, how much involvement do you like your patients to have? Who decides when to discharge, you or your patient?
- Money is important, but it isn't the only reason for choosing OT as a career. What other rewards, do you think, are important?

THE VIEWPOINT OF PRACTITIONERS

Altruism

Flexner (1915) predicted that altruism would become increasingly important to the professions but in more recent times this does not seem to have been the case (Hugman 1991). To what extent did this group of practitioners consider their profession to be altruistic?

Forty four percent thought that occupational therapy was an altruistic profession, a view shared by this practitioner.

OT27 (mental health): Actually I do believe in that because I feel we can... We don't have the moral high ground but I think that we do have erm a philosophy that involves... health comes through activity and well being comes through well being and therefore... we can make a difference.

In contrast, 30% did not consider occupational therapy to be altruistic. As in this case, they took a pragmatic view.

OT15 (physical): I don't think we're all that erm idealistic... I think some people might be but erm I don't think we're here for the greater good.

It seems that many practicalities mould altruistic intentions. For example, Blom-Cooper (1989), in his report, concluded that the philanthropic origins of occupational therapy had led to a damaging stereotype of its members as 'do-gooders'. This was an idea shared by some practitioners, who thought that altruism in modern day professionalism could be detrimental. For example, this occupational therapist argued that the power to demand high remuneration was weakened.

OT11 (mental health): I think there has to be an element in there... and I think... that is... because there is that element in many health care professions that's why we get stuffed... on every pay round... you know... there's a kind of balance.

Moline (1986) thought that few people could live up to the onerous task of living for the interests of others. The following practitioner agreed, highlighting the idea that total selflessness is a heavy burden, which may result in mental and physical fatigue and ultimately ineffectiveness.

OT1 (physical): I think it's a bit... sort of you get a bit of the martyr syndrome really 'and I only do good' you know and I think...it... There's a risk there that certainly people get burn out and feel like they need to solve all the problems of everybody.

The same respondent also observed that because occupational therapists work with resource limitations, in bureaucratic organisations, they are not in a position to offer an unrestricted service to patients.

OT1 (physical) We have to cut back... rationalise our service which is a *real* issue in terms of, that we want to provide the best sort of service for our patients and sort of, you always want the best but...it... We can't provide the best given the restraints that we're working within, you have to get that balance.

According to Larson (1977), people were unlikely to undergo a lengthy and difficult education unless they found their work interesting, rewarding and bringing privilege. Thirty six percent thought that there might be elements of altruism but the intrinsic value of the work was more pronounced. The following practitioner, who demonstrated a caring attitude whilst stressing the personal satisfaction gained from doing interesting work, made this point.

OT34 (mental health): I'm fascinated by the mind or whatever, so I find it extremely interesting... And from an OT focus the fact that you're engaging people in something that they love doing and they would do normally... but you can see them improving and getting better through doing that... rather than just being... full of medication or... and that's really nice.

Freidson (1994) thought that people who found intrinsic value in the work were motivated to perform it well and at the same time bound to a community of like-minded colleagues. This seemed to be the case for these practitioners: the rewards were derived from bringing improvement into a patient's life. Many became quite animated when recalling a successful outcome to their treatment. Although a large proportion considered occupational therapy to be altruistic, most thought other factors conspired against it being a practical part of professional life. It is not always compatible with professional motives, making higher financial remuneration less likely, for example. Intense commitment can reduce the intrinsic value of the work, resulting in problems of staff retention due to fatigue. Because occupational therapists do not have full autonomy, they are not in control of resources, which limits the potential for altruism and therefore it is an unsustainable aspiration. However, finding intrinsic value in their work and the status that it attracted, was very important. In order to explore what it was that the practitioners found essentially worthwhile, they were then asked what rewards they derived from their work.

Rewards

The practitioners were asked what they considered to be the rewards associated with being an occupational therapist. Eighty nine percent of the group considered that the main reward was in enabling patients to bring about positive change. This majority view was expressed well by this respondent.

OT21 (community): For me it's the small things. We had a lady here this morning doing her breakfast... She hasn't really been in hospital before and she doesn't like it and she thought she was never going to get home or she was never going to be able to do anything... So we've had her in here the last two mornings making her breakfast and she said to my assistant 'You've put the light back into my life that I thought I'd lost'. Something wonderful like that, this little old lady came out with this morning and I thought 'well that's what it's all about'... They're the sort of things that make me think I've done a good job.

Seventeen percent thought that being part of a team was rewarding. The importance of this, in terms of pride and esteem, can be seen in the following quote.

OT20 (physical): I think the most important thing that you hear is that the OT's are working as a team. We've got a fantastic team that work together really... you know the people that work here they're... you know it really is a very, very good department and that means a lot.

Other factors included variety of work (14%), meet interesting people (8%) or having a professional status (8%). Only two respondents mentioned issues of self-

interest. This practitioner for example, highlighted the holiday entitlement, opportunity to travel and the hours of work.

OT12 (mental health): 28 days annual leave compared to like 20 for some of my friends. The ability to... especially for me, to be able to go off and have two years travelling and come back and still be able to get a job... I'm hoping... And also related to that the ability to go and work abroad erm...erm... Again the hours, you just do your nine to five there's not really that much overtime, you're not being expected to stay after five because your boss says so... working in big NHS Trusts where you've got support and backing from personnel and those kind of things.

The vast majority of these practitioners reported non-pecuniary gains as the rewards for doing this type of work. Enabling patients, team working, job diversity and meeting interesting people were all highlighted. Very few people cited self-interested motives, a steady career, a pension and the status of being a professional person. Only one respondent thought that pay was worthy of note. As a group they were more inclined towards the craftsmanship ideals referred to by Larson (1977) which involved doing a job well and for the benefit of society.

These results reflect those found by Craik & Zaccaria (2003) who investigated the factors that influenced occupational therapy students' choice of career. Variety of work settings and issues around helping people made up the first six factors ranked in order of importance, whilst professional status and good salary were in the lowest five. However, because occupational therapists have a choice about specialisation it was likely that they would make judgements about the worth of some jobs relative to others. An exploration of the reasons why some areas of work were considered attractive or unattractive could reveal the motives behind those choices. This is addressed now.

Choice of Work Setting

The notion of gaining status through work can be illuminated in the type of work that occupational groups choose to adopt. Hugman (1991) noted that some of the service professions have opted for higher status activities and avoided the 'dirty' (low status) work characterised by Hughes (1981). According to Hugman the status of an activity is dependent on age and the characteristics of the service user. In general, work with children is accorded a high status in contrast to the low status of work with the elderly. There are, however, subdivisions: for example, work with children who have learning difficulties is less valued than those with leukemia and work with the elderly who have acute problems is more valued than those who have long term problems. Professions have tended to stress the glamorous, prestigious aspects of the work, often those that are most closely associated with a theoretical base and aimed at curing or problem-solving rather than merely relieving suffering (Hugman 1991). Devotion to duty, therefore, if applicable at all, is reserved for specific areas.

The practitioners were asked what they considered to be the most attractive fields within occupational therapy. The results are listed, the percentage referring to the frequency with which they were mentioned.

Table 8: The Attractive Fields of Occupational Therapy

FIELD	%
Paediatrics (specialist areas such as child psychiatry)	44
Neurology	39
Hand therapy	22
Social services (new innovations such as community rehabilitation)	22
Mental health (specialist areas such as forensic psychiatry)	17
Burns & plastics	8
Spinal injuries	8
Orthopaedics (specialist areas such as trauma)	5
Learning disabilities	5
Oncology	5
Amputees	3
Accident & emergency	3
Rehabilitation	3
Locum work	3

The reasons for their answers were then explored. Sixty one percent considered that it was glamour or status that made an area of work attractive. If an area was high profile or science based or linked to medicine it was seen by others as impressive, which was helpful to the self-esteem of the occupational therapist, as the following quote illustrates.

OT31 (community): There's a lot of street cred I guess... I don't think there's anybody, hand on heart... you want to impress somebody somewhere, whether it's your parents or your friends... or prove to yourself that you're a bit better than you thought you were.

The potential to produce demonstrable improvement, if not a cure, in the patient, was significant for 19% of the group. The following practitioner made this point.

OT30 (mental health): I've worked in psychiatry... you get such a short amount of time... dealing with such a large amount of problems you're constantly chasing your tail... Whereas with people in forensic section you have got a much longer period of time, there are definite things you can achieve before they're released so you've actually got time to work on the condition... so that's one of the things I really like about it.

The idea that working for institutions with a good reputation confers some glory, and as a result, higher esteem, onto occupational therapists was expressed by this practitioner.

OT23 (physical): A lot of my friends when we were training, they wanted to work in the big hospitals er and be at the front of things... I've definitely found... I've worked in teaching hospitals and [this hospital] is very much more advanced in terms of creating services that are right. Research erm evidence based practice, all those kind of things that they never did at the other two hospitals... and the profile of OT is so much higher.

Fifty percent thought that an area was popular when it harmonised with an individual's personal interest and therefore had intrinsic worth, as the following extract demonstrates.

OT32 (community): I don't think there is an unattractive side to OT... but I think there are people... who er are better predisposed to go into those areas... and by and large they generally filter into those areas.

Twenty five percent of respondents acknowledged that their particular area was widely perceived to be unpopular. However, as this practitioner explained, there is always the potential for job satisfaction.

OT11 (mental health): You know you're on a hiding to nothing to a certain extent because... the clients are... you know everyone's got a prognosis of 25 to 30 years erm. So you're looking at small rewards and I think to sort of go in there and say well ok I'm going to see this person who's not going to do very much for 25 to 30 years but I'm going to maintain... Maybe we'll pull some rabbits out of the hat, maybe we'll get something to happen for them occasionally... is a very different... er ... demand on the professional... yeah I wouldn't pretend that this is more... for me it's more groovy than doing neurology.

Most practitioners then, found status in work defined as glamorous; an idea consistent with Hughes (1981), that work was important for social identity. Once again, personal interest and the intrinsic worth of the work were highly regarded. Hugman (1991) noted that the potential for patients to be cured was necessary to the status of the work, although this was true for a relatively low proportion of the practitioners in this study. Twenty five percent of the group found satisfaction from working in an area that was generally perceived to be low status. Perhaps these people were more altruistic in their orientation but, within this section, only one had considered occupational therapy to be altruistic. It could be argued that if they were truly altruistic they would work in the areas of greatest need regardless of whether or not they enjoyed it. I would therefore suggest that, for there to be intrinsic value, there must be personal interest. Nevertheless, given that they

worked in areas where recruitment was difficult, they should be fostered and valued as people who give the service ideal some substance.

The fields perceived to be unattractive are listed below, the percentage referring to the frequency with which they were mentioned.

Table 9: The Unattractive Fields of Occupational Therapy

FIELD	%
Elderly	33
Mental health	30
Learning disability	19
Orthopaedics	17
Social Services	17
Acute hospital work	14
Paediatrics	5
Young disabled	3

Forty two percent of respondents considered that the reason why an area of work was unattractive was that it was low status or menial. This point was made clear by this practitioner.

OT29 (physical): Care of the elderly is unattractive, bottom wiping... which is awful because I just think that is bread and butter OT and is just such a huge part.

This respondent highlighted aspects of work that were undemanding and did not justify training.

OT3 (community): ...(2)...I think... medical side and orthopaedic side is probably for me the most unattractive section erm possibly because it's regarded as very... very procedural again very... This is what you do quite black and white... in many respects er very much, like you can have this equipment and probably the belief that... anybody *could* do that.

This quote reflects the view of 11% who thought that some occupational therapists prefer not to be associated with fields that have a poor image in lay culture.

OT8 (physical): Things like mental health and dementia, you know people just getting old and incontinent... You know, they're the sort of things that people tend to hide away and they're not something that people want to put them into glossies and on the television. And you know it's like this 'Children's Hospital' and 'Maternity Ward'... it's all the things that give a nice story and people with dementia, schizophrenia and manic depression it's not a nice story... they don't recover.

It was a generally held view that fields such as the elderly, orthopaedics and acute hospital work were unpopular because pressure to discharge patients as quickly as possible has reduced occupational therapists' capacity to perform the work well. This has led to a systematised, inappropriate form of service delivery, which has become, as this practitioner says, like a conveyor belt: a metaphor befitting the business orientation of the modern NHS.

OT24 (community): We do total hip replacements and I often think, I have a big problem with it because I just feel like it's conveyor belt erm... Just the general medical I couldn't, I'd find it quite hard to go back to doing OT... ADL assessments and home visits for discharge because I don't... actually working in primary care... I have a problem with it because it's not appropriate... it doesn't make sense... I always feel you could train other people to... Technical Instructors to... [do that].

The point made in conjunction with this common opinion was that hospital workers are all under pressure of different kinds, which filter through the hierarchy. Doctors need to clear beds to make way for new patients, for example, which pressurises occupational therapists to do the same. As the following quote demonstrates, the result is that the patient receives an inferior service.

OT9 (physical): Elderly tends to be not popular because it's crazy... because you've got so much work to do and you don't get the contact time with the patients... You are very much an equipment provider, a discharge facilitator if there's a lot of pressure on from the consultant and nursing staff.

A further 11% thought that lack of potential for improvement in a patient group was a contributory factor, as this practitioner reported.

OT19 (physical): Learning disabilities... I loved when I did it as a student... I wouldn't want to do it now there's not enough... I'd hate to say I'm an OT for personal gain but the speed of improvement is such that... you know it must be quite soul destroying at times. You know you manage to gain eye contact after a year of work with someone... it must be hard to maintain that level.

Just as personal preference was influential in practitioners' career choices it also, of course, helped them decide which areas to reject. This practitioner, for example, found children, as patients, too emotionally demanding.

OT17 (community): Me personally not children because er I've had my own [laughter] and I couldn't take the emotional side of that, it wouldn't suit me... to see someone elderly dying is one thing but to see some of the children dying I couldn't hack it... I didn't want that.

The first thing to note is that mental health, learning disabilities, orthopaedics, social services and paediatrics are mentioned in both lists. This duplication can be in part explained by individual preferences but, when people referred to an area such as mental health, they qualified it by specifying specialist sections; forensic psychiatry and so on. It illustrates the complexity of arbitrating attractive and unattractive areas. Most agreed that areas that were not intellectually taxing, did not match the professional knowledge base or had a poor image in lay culture were considered low status. Once again the proportion of respondents citing lack of improvement in the patient group as a deterring factor was relatively low. More significant was the need to cope with large numbers of patients, which prevented them from performing the job well, the effect being to reduce the intrinsic value of the work. Occupational therapists working in acute hospitals felt a loss of control about what form the job should take and many thought that they were being used as 'technicians' rather than professionals. As such they were being undermined. The practitioners then, were making clear judgements about choice of work setting. The natural consequence would be an uneven distribution of service delivery; the next area about which they were asked to reflect.

Equity of Service Provision

Equitable service provision is complicated by the fact that practitioners exercise choice in the areas of work they adopt. The result is that there are always high vacancy rates for occupational therapy posts in the care of the elderly and competition for posts in neurology, for example. The practitioners were asked to consider what this scenario said about the service that occupational therapy provides.

The majority (86%) reported that the public perception must be that occupational therapists found care of the elderly uninteresting. This view was expressed in the following extracts.

OT10 (community): The message is that it's not terribly serious... it's not taken... it doesn't have much professional clout... it isn't that important.

OT12 (mental health): I suppose it's giving out the message that OT's don't value working with the elderly.

OT29 (physical): Perhaps they think that it's less interesting, less dynamic because you can't be dynamic with the elderly, do you know what I mean? That's the image.

For 8% of the group, staff shortages could be useful to highlight the value of occupational therapy and for this practitioner, competition for posts raises its profile, particularly if they are within high status organisations.

OT35 (mental health): I think the fact that there can be... vacancies and gaps... although a shame and a tragedy for the patient... emphasises the importance of OT because the establishment remains respected and protected. And I think that there may be stiff competition for a limited number of posts might speak about that particular institution, might be a famous and popular institution.

Any claims that these occupational therapists are altruistic therefore, can be laid to rest. They are fully aware that the greatest demand for health and social care comes from the elderly population, yet the numbers who choose to work in this area are relatively few. It is a happy coincidence that those who do so find that it matches their personal interests and skills. Status, prestige and reputation are the rewards they look for. They can bask in the reflected glory of working for a renowned organisation but the work must have intrinsic value in order for them to want to perform it well and intrinsic value is dependent on personal interest. Occupational therapists have the freedom to work in any area they wish. There is an expectation within the code of ethics that patients also have choices but this does not always sit well with professional motives. The practitioners were next probed about this issue.

Patient Choice

When Goode was writing in 1969 it was the professional who decided patients' needs without regard to their wishes. An occupation would be classified as less professional if the patient imposed his or her own judgement about treatment, since authority to define what was best, will have been undermined (Goode 1969). This was a source of tension between practitioners trying to do their best to help patients whilst at the same time exerting their authority. Johnson (1972) considered this to be a by-product of collegiate professionalism; that the client might request help but it was the professional who controlled intervention and discharge and under such circumstances consumer choice was nullified. More recently, there has been a drive towards involving patients in their treatment. The Code of Ethics for Occupational Therapists (College of Occupational Therapists 2000) directs that patients work in partnership with therapists and should be allowed to exercise choice. But does this happen in reality? Morrall (1997) undertook a critical analysis of the professional status of psychiatric nurses working in community health teams. The results demonstrated that, although nurses were under the authority of psychiatrists, they managed to exercise their own autonomy in certain areas. For example, they were able to control the type and frequency of treatment offered and when to discharge a patient. Moreover, they did not engage their patients in discussion about the episode of care.

The practitioners were asked about the extent to which patients were involved in their treatment and discharge. This quote reflects the view of 30% of respondents who felt that there should be a strong patient/therapist partnership.

OT10 (community): Very, very, very... 100% erm and when I'm doing the assessment I, one of the first things I always do... at the stage of filling in the form is to say that *this* is a 50/50 relationship... This is a relationship that hopefully will be based on respect erm and I consider that whatever your views are I will take you seriously and that will be included in the treatment plan. It's no good me trying to plan a treatment that they haven't had any input into it's just not going to have... the outcomes that both of us want.

Although 50% of respondents reported that they involved patients in treatment planning it was not as straightforward as it seemed. There were limits. For example, in these extracts, commitment to patient engagement was used in theory but, in practice, the occupational therapist was guiding the level of service to be delivered. Some discussion was allowed but the authoritative expert was evident.

OT33 (community): We can make recommendations and say I want x, y, and z... which is what I feel is good for you... but a lot of them will turn round and say 'I could do with an extension'... Yes, in an ideal world we could all do with an extension but unfortunately our resources, our criteria... your need... in *my* assessment dictates that we do this... If you're not happy, you have every right of appeal.

OT12 (mental health): Erm ... here I'd say that every team decides what types of intervention are going to be used... But then the individual sessions erm... I'd say it was quite equal... the person might lead it and express what they're saying but then after I'd try and channel that to them... help them make changes.

OT19 (physical): I'm not saying to them, 'what activities would you like to do?' Because the sort of things we're using they wouldn't know what to choose.

Present thinking directs that all patients should be involved in the decision making with respect to their care but this is not always appropriate. Some patients, especially the older ones, have been influenced by a culture where trust in the expertise of a health professional should be taken for granted. These patients expect and are happy to comply with, what they view as authoritative decisions from occupational therapists. This practitioner found that quite challenging.

OT21 (community): It depends on how involved the patient wants to be. Sometimes they don't... they just want to do whatever you... 'I'll do whatever you advise, whatever you think is right, I'll be guided by you'. We get that quite a lot as well... but we want them to say what [they] want.

Some respondents, especially those in physical health care, found the volume of patients meant that there was little time for everyone. The following quote reveals how this affects the chance to engage patients fully in decision making.

OT20 (physical): I always find this a difficult one because... I mean my patients... people I'm seeing... are very much probably a once or twice erm... face to face.

On occasions giving patients too much choice creates conflicts with other agencies. In this example, the patient's right to refuse a piece of equipment has infringed on health care workers' health and safety rights.

OT2 (community): I mean one of the biggest issues that we have... that there's conflict with are the manual handling issues... Because we quite often get called in at the point where... either social services or private agency carers are actually going to withdraw services because of a manual handling issue... if the client refuses to comply... you've then got a dilemma, which way do you go? And you know you've got... Training will say well... it could be handled erm... That's the best we can make of the situation taking into account... the patient's wishes not, for arguments sake, to have a hoist erm... And then the other hat says but legally... we have a no lift policy... patient's none weight bearing... that sort of quicky swivel pivot transfer will no longer wash, can't do it any more erm... so there's a lot of conflict with that.

For 17% of respondents, discharge from treatment was a multi-disciplinary decision. Sixty seven percent however, controlled the discharge of patients. As in this example, there was some negotiation with the patient.

OT25 (community): I think it's a joint decision really erm, you know. If I feel that the patient's perhaps achieved their goals as far as they can I then discuss that with them and find out how they see their progress and if they feel they can progress a little bit more and discuss it with them erm. And then think about, you know, saying to them 'look it's perhaps time to discharge you if there's nothing else that you feel that we can do for you, that we can work together on really'... That's sort of how I do my discharges.

For most however, the decision was more authoritative, as the following quote reveals.

OT29 (physical): I've started writing actually in the notes... If I feel there's nothing more I can do or if... say if they had a splint or a brace and they don't need it anymore for that episode and there's nothing more I can do then I *will* discharge them from OT.

At one level, the practitioners welcomed the idea that patients should participate in their treatment and discharge. Yet, if someone in the community requested a piece of equipment that was counter to the therapist's recommendations, it was not provided. In hospital situations it was the therapist who decided what form the treatment should take. Discharge, for the most part, was directed by the occupational therapist. But there were other considerations to take into account. Decisions were often authoritative but with some justification: some patients might expect it, high case-loads mean that there is not enough time to offer a choice, there might be consequences, such as someone refusing the use of a hoist compromising the safety of the carer who performs the handling. Nevertheless, professional autonomy was exercised to an extent that reduced patient choice.

In summary, these occupational therapists were not altruistic; they were not prepared to work in areas that held no personal interest. No evidence of cynicism was found, however. Becker et al (1961) took issue with the common conception that medical training destroyed the idealism of students and replaced it with cynicism. They argued that the situation was more complex than it first seemed. Students started from a naïve position but later learned to apply idealism to specific circumstances. The practitioners in this study were also discriminating in their idealism and demonstrated a service ideal at certain points. When they worked in areas they found interesting their enthusiasm for doing their best and the excitement they felt when success was achieved was clear to see from some of the extracts. They gained satisfaction from enabling people to become independent, the variety of work and colleague-ship. Relieving suffering and improving quality of life was more important than the potential for cure. They took pride in the status to be gleaned from working in glamorous jobs, for respected institutions, and in their reputation. These were the rewards.

Areas designated as low status were considered menial, uninteresting, literally dirty in some cases (toilet care of patients) and to be unworthy of the professional expertise. Some felt that the poor image of certain areas of work, in lay culture, reflected badly on those who worked in them; the perception being that occupational therapists working in care of the elderly were not good enough to work in more glamorous jobs. Where there was a lack of autonomy of work, occupational therapists were denigrated as technicians. There was little doubt that some of these practitioners were devoted in their duty and there were some that derived satisfaction from working in areas generally considered low status. However, the fact that they were discriminating in their idealism has tempered the notion that they have fully adopted the service ideal. Rather than putting self-interest aside for the benefit of the patient, unequal provision of care has been created, making the elderly a 'Cinderella' service, for example. They were prepared to involve patients to a degree but were firmly in control of the content of treatment and its termination. The practitioners wanted to do their best for patients but under their own terms.

Similar questions were posed to the College of Occupational Therapists (COT) representatives, whose views are presented in the following analysis.

THE VIEWPOINT OF the COLLEGE of OCCUPATIONAL THERAPISTS

Altruism

Four of the seven COT representatives did not think that occupational therapy was an altruistic profession. This quote was typical.

COT4: I tend to feel that people gravitate towards the professions, or anything else in life, as much to their own needs as to the... others.

The other three thought that it was altruistic although this extract indicated a general opinion that it was not helpful in a competitive environment.

COT6: As far as anything is altruistic yes I think it is... erm in that I think it... it is very concerned about others, other professions and other people... sometimes to its detriment. There are occasions where coming from another part of the... another profession I think... we ought to stand up for what we believe in more strongly... even if it does hurt a few other people.

This split reflects that within the practitioners' group although the proportion taking the negative view was greater among the COT respondents. The perception was that altruism undermined the power base, and weakened the ability to compete with other professions. It therefore did not have a large part to play in modern professionalism. They thought that people chose occupational therapy for their own reasons. So what rewards did the COT representatives expect occupational therapists to derive from their work?

Rewards

The respondents were asked to consider the rewards of being an occupational therapist. It was a question that surprised some people initially.

COT1: I don't think I've told people that for ages actually! It's a long time since I've had to sell the profession.

On further reflection, six considered that variety and the intrinsic value of the work were the most important rewards, a view expressed in the following quotes.

COT5: The flexibility and the variation of where you can actually practice and the number of skills that you can still acquire throughout your education

COT4: I think that OT's generally would say that it's the satisfaction of...(2)... working with... people and feeling that... that the feedback from them is that they have met goals that they have worked on so that is how occupational therapy... works at its best.

One cited the job security.

COT2: Well I suppose the first is you'll never be out of work ... unless you're very choosy ... you'll never be out of a job.

Another highlighted the status of a degree.

COT5: I also think... if I have to be honest... stuff like a BSc... people are attracted to that as well.

Although it took time to extract this data, reflecting perhaps the distance between COT and its members, the rewards they cited broadly matched those from the practitioners. Since the role of COT partly involves the promotion of the profession and the service it can offer to society it was interesting to examine, from these representative's standpoint, how the service was being delivered.

Equity of Service Provision

Attention was directed to the fact that some areas within occupational therapy were considered popular to a greater or lesser extent. The respondents were asked to reflect on what this said about the service being offered. Five respondents thought that it mirrored the values of society. The point was made in this quote, that some groups of people would always be discriminated against.

COT1: Services to elderly mentally ill people... or people with learning disabilities... they are... services that are marginalised and stigmatised anyway because of the client group and the more or societies attitude to those particular people erm and I think the profession reflects that.

Three respondents were not especially concerned that any detrimental message was being emitted. This extract demonstrates a nonchalant stance, for example.

COT6: Well it sends out messages that OT's are human and OT's make choices... which are about their needs as well as other peoples and you get very similar messages from other professions.

Two thought that it was not something, for which the COT had any responsibility, a point made in the following quote.

COT1: ...(3)... I suppose it... it's... can it? Because... in terms of providing services that's what the employers do, or organisations, whether they be voluntary or statutory... it's they who... provide the services... it's they who... employ the staff... so what the College can do ... In that direct way is probably not a lot.

This was a rather complacent response. The practitioners overwhelmingly thought that the shortage of staff in care of the elderly portrayed, to the public, a

message that occupational therapists were not interested, which countered the service ideal. The COT representatives, in contrast, regarded it as natural, a reflection of society's values and not of much concern to the professional body. They were then probed further and asked to consider the ways in which the COT could encourage greater equity of service provision, something, which is stressed in the Code of Ethics.

This respondent considered that occupational therapists had championed the cause of the elderly.

COT4: I think occupational therapy has been on the whole erm pretty exemplary in its ability to er raise the needs of the elderly population for instance as being... a large and important clinical... the services are important.

As a strategy to improve recruitment in low status fields this representative thought that COT could promote them in a positive light.

COT2: I don't know how you change that ... you could always raise the profile [make it] more the flavour ... of the time, it might create more interest raising the profile of rehabilitation ... that kind of thing.

Two thought that COT should promote the positive image of occupational therapists that have chosen to work in low status fields, as this respondent explained.

COT5: It's about promotion of those fields to me, I certainly, whenever I speak at... to the students I always say... you know... Just to say if you're going out on placement... because you used to see students come out and they used to dread... *dread* the elderly placements, you're washing and dressing them... and you might end up having to change somebody and, you know, all those kind of things. I tend to sort of reinforce or reiterate... you know... don't be put off by going anywhere like that regardless of... it's not the most glamorous... you know. In your own mind you're going to learn an awful lot of information there and you're going to have an amazing time and learn more... Probably... I gained more life experience through working with older people throughout my career than I could ever hope to achieve.

Four respondents thought that unpopular areas of work should be made more attractive through fieldwork placements and publishing work, which emphasised the positive aspects of low status fields. The importance of such action was emphasised in the following extract.

COT3: We know that places who offer fieldwork places to students fair better. Students come back and work for them and also where there is

erm... career progression people will stay in the system and so we have done work like encouraging fieldwork placements in social services so people will come back and work there. We have done things like er... commissioned reports and studies on good practice, collaborative working that sort of thing tried to publicise things like that er... with priorities for research so that we know what areas could be... you know, need work on.

Four respondents considered that occupational therapy managers played an important role in recruitment to difficult areas. This comment was typical.

COT7: The thing to do is to bring on the departments and to get people to realise that you need good management practice in occupational therapy and good management practice to support... occupational therapists.

It would be disingenuous to suggest that COT was unconcerned about equitable service. COT does have strategies to encourage people into low status areas of work; it has published evidence based practice guidelines for those with learning difficulties and the vulnerable elderly, for example. Yet, despite such actions the respondents placed a heavy emphasis on the idea that responsibility for recruitment into difficult areas lay with occupational therapy managers, as this extract shows.

COT1: Whether it actually then translates into more interest, more recruitment, more posts it's like those are... What I was saying about the gap between what the College can do and what happens on the ground... In fact there's lots of stages between... us saying occupational therapists can have a lot to offer in that area and we've given it a high profile, between anything then happening on the ground.

The COT representatives were less inclined to believe that occupational therapy was altruistic but they generally agreed with the practitioners regarding the rewards to be gained. COT could be accused of becoming remote from the practicing membership and having directed their interests towards professional advancement rather than the ideal of service on which occupational therapy was founded. They did not see unequal service provision as their specific concern. Promoting the less glamorous areas of occupational therapy was given some consideration but the ways in which the ideal of service is enacted in reality has been delegated to the practicing membership. The attitude was that the COT could only do so much and it was up to occupational therapy managers to translate strategic planning into action.

Attention was then turned to an analysis of the educators' interviews.

THE VIEWPOINT OF EDUCATORS

Altruism

Only one educator thought that occupational therapy was an altruistic profession but they highlighted aspects of beneficence and there was a strong sense of the service ideal. As one put it,

T4: A large part of our job is giving... instilling hope in people.

Educators are in a unique position to understand the motivations that drive students to pursue their career and so the opportunity was taken to examine this in some detail.

Rewards

The respondents all thought that the main reward of being an occupational therapist was to be found in enabling people to improve their lives. This educator found the same satisfaction from working with students.

T3: I think it's... the satisfaction... that you can't change the world... but you can actually...(1)... help to facilitate... some improvement... in quality of life... and it... be it... for the... the client...(2)... the service user... or the carer...(2)... And I think that's... that's the satisfaction element there... and I have to say I get the same with the students.

Even when there was no hope of a cure, for example, in cases of dementia, there was satisfaction to be found in improving quality of life, a point made in this quote.

T4: Even... a small step... like keeping somebody at home for a bit longer...(1)... a few months... longer... maybe...(2)... [gives a]... a lot of job satisfaction...(1)... because I know how important it is for... most of the clients... a little thing like that.

A number of reasons behind the career choices of occupational therapists were identified. The intrinsic value of the work was a prime motivator. It needed to be interesting and stimulating. The patient/therapist relationship was important but so too were personal preferences. The following educator came to these conclusions after listening to students.

T1: I think people will work in any area where there is... stimulating work going on...(2)... when... I think a lot of OT's... certainly our students... don't want to work on assessment wards... because they are seeing that as students... and they're coming back and saying... 'Yeah...(1)... it's boring... you know we can't... form a relationship with a client... all we're doing is assessing for discharge'. They don't really... want to know

anything about long-term rehab... it's very dissatisfying personally... there's no job satisfaction there. Now other students will go in and say that's the area I want to work in because it's quick... it's buzzy.

The perceived glamour of the work was another factor, for this educator.

T4: I think mental health... tends to be bottom of the pile...(2)... often... and... older people's mental health... is right at the bottom of the pile...(2)... but the trendy one... things like forensic... (2)... become trendy...(2)... uh... or... working with younger people... and doing dynamic stuff... like drama therapy.

Conversely, practitioners that worked in areas perceived to lack glamour had doubt cast on their competence, as this educator explained.

T4: Mental... health... with older people...(1)... is seen to be...(3)... uh... not a priority...(1)... and some other professionals... often think... it's where you go...(1)... when you're not good enough to work with adults.

A view that government priorities had a certain amount of influence on practitioners' perceptions of sectors of work was reflected in this quote.

T1: They [care of the elderly etc] are not a priority... for government...(1)... they are not perceived to be a priority... I mean at one point... what ten years ago HIV and AIDS were such a priority that everybody wanted to work, you know, within that area because that's where all the money was...(4)... em...(1)... now you know suddenly it's... cancer and... heart.

In fact, according to the government's *Priorities and Planning Framework* (Department of Health 2002-2003a) the clinical priorities are, in addition to cancer and coronary heart disease, also mental health and older people. That being the case, initiatives such as the National Service Frameworks for the elderly should have a positive impact on occupational therapists' perceptions of the work, according to this respondent.

T4: I think the government... it it's good that we were talking about National Service Frameworks more as well...(1)... it's good that the government [have]... brought one out for older people... to remind us what...(2)... things we should be addressing.

The educators agreed that the most rewarding aspect of occupational therapy was in enabling people to have an improved quality of life, even when there was no chance of a cure. In their opinion, occupational therapists looked for the work to be stimulating, interesting, to have intrinsic value, status and glamour. Personal

interest was also a factor, which decided whether or not the work would be rewarding but educators were keen to stimulate interest in all areas of work, including those deemed less glamorous.

Equity of Service Provision

Educators were concerned to impress upon students, the relevance of the service ideal and equitable service delivery. This respondent, for example, stressed the role of educators in encouraging students to look for intrinsic value in all areas of work.

T3: I am... not sure... it's... totally about...(2)... the clinical area...(2)... because we very much... try to encourage students... that all clinical areas have positives... and all clinical areas have negatives...(2)... uhm...(1)... And I've had students come through... who have said...(1)... no way I'm working with the elderly... and have gone out to be head OT's in elderly units.

According to this educator, a change in educational emphasis has made it more likely that new graduates would be attracted to unglamorous areas of work.

T2: I think a lot of the things we now value in OT... er it's not so much the technological aspects of OT but it is more the spiritual aspects of OT... em... er you know... The holistic aspects... the... the aspects more concerned with the... with the person... and... and... environments and occupation. ... And those...(1)... can be... you know if you really believe in all that... then... then the area... I would have thought you'd want to work in would be... older adults... because... you know...(1)... [those] fit so well... with these people.

Educators used many ways to encourage interest in those areas of work that proved difficult to recruit. The following quote gives an example.

T3: We had a situation where... we knew there was a limited opportunity for students to go into... learning disabilities...(1)... and we had two therapists... who were doing wonderful work... in learning disabilities... and a service user... who was willing to come...(2)... And the students had a wonderful morning...(2)... talking through this persons lifestyle... and what had happened... and what they were doing now and everything...(2)... and it brought...(3)... it brought leaning disabilities... alive... to students...(2)... And I think it's that... to bring... that opp... you can't do it for everything... but it's bringing that opportunity... as far as you can... alive...(1)... and by students coming back... from placements... and sharing... their experiences... with each other.

According to this educator, personal interest was key but exposure to fieldwork

placements and interaction with peers were also significant.

T1: I think it comes back to students personality and interests... whether they have good... or negative experiences as a student on their placement... what they hear from other students... as well... through the grapevine.

The educators considered that occupational therapists, who were in positions of role model, were valuable influences by transmitting their enthusiasm for the work, a view expressed in the following extract.

T1: I think it comes back down to the people who were working in those units... If they're working in a unit and they're enthusiastic... and they've kept their motivation up and they're doing really good OT... then they will attract people.

As a group, the educators were the most keen to instil into students the idea that all areas of work had the potential to be satisfying. The service ideal was emphasised. Several techniques were employed to steer students towards low status areas of work. These strategies included personal involvement, changing the educational direction, for example, but also using exemplars of good practice as inspirational models.

To summarise the educators' point of view, most did not think that the profession was altruistic. From their standpoint, the satisfaction of occupational therapy comes from enabling people to have an improved quality of life. This applies to those people who have deteriorating and terminal conditions, echoing the philanthropic ambitions of the founders of the profession. Although they are driven by personal interest, practitioners want to find intrinsic value in their work. They are drawn to the more glamorous areas because it makes them feel valued. The competence of staff can be questioned by virtue of them working in low status areas. Their social identity can, therefore, be compromised. Educators take seriously, their responsibility to instil the service ideal in students, which might steer practitioners towards equitable service delivery. There are several factors that contribute to practitioners' perceptions of areas of work: government priorities, exposure to fieldwork placements during education, interaction with good role models and so on. Although shortages of staff in certain areas can emphasise the exclusivity of occupational therapy the educators were striving to generate an even distribution of service.

Finally, the views of the Council for Professions Supplementary to Medicine (CPSM) were analysed.

THE VIEWPOINT OF the COUNCIL for the PROFESSIONS SUPPLEMENTARY to MEDICINE

Altruism

This quote represents the view of all of the CPSM respondents who thought that altruism was still a professional attribute.

CPSM2: There's an element of altruism in all of us I think

However, the ideal of service has become qualified over time. This respondent recalled the historical view.

CPSM2: People went into health professions and into occupational therapy because there was a sense of service... and on that... that was a generation... well that was a whole generation ago.

But, as the respondent continued, the present situation is different.

CPSM2: I'm not sure whether service is the right word now. I think it's an old fashioned word but I still believe that people that go into professions like ours... genuinely... want to do good in the broadest... sense. And want to feel as though they are... erm... enabling ... disadvantaged people... to... overcome those disadvantages whatever they are.

According to this respondent, all professional groups to a greater or lesser extent have power interests.

CPSM3: There is that temptation which is not altruistic it's about status... power and status within a pyramid.

But it was less evident in the case of occupational therapy.

CPSM3: I don't think occupational therapists have it as much... because you have also other interests.

Altruism was important to this group. So too was the service ideal although this has evolved and self-interest has been allowed to infiltrate. Not all of these respondents were occupational therapists themselves but they did have an overview of the profession. So what did they think were the rewards of being an occupational therapist?

Rewards

Beneficence and variety were considered to be rewards but glamour and links with science were also factors, which made work attractive, a view suggested in this quote.

CPSM2: I think there is a cache with some of the more... romantic or... type jobs like neuro... which... a lot of neuro is based on research and science as opposed to the art of occupational therapy... I'm not saying there isn't any but there's more... research... background or basis of clinical and practice development, in things like neuro... and also I think... erm to some extent in things like... some of the psychiatric side like forensic psychiatry.

In this respondent's opinion, the distancing from the moral dimension of professionalism and the increase in self-interest, has been regrettable.

CPSM3: The... rewards are good old fashioned rewards of getting a good job done... I think it's a very important dimension which I'm afraid... over the last twenty years has been played down tragically to our cost... Of social responsibility, of being a part of a caring system of being... part of a socially responsible system.

Beneficence and 'doing good' were in the forefront of occupational therapists' minds according to the CPSM representatives. However, many of the rewards centred on an improved social identity, glamour and the kudos attached to those areas of work that have links with science and research; self-aggrandizement in other words. As a consequence, the morality that was associated with the professions in their early history has been undermined, which may lead practitioners to choose areas of work that satisfy their own needs rather than those of the patients. In their position as regulators, this group should have an objective view as to whether or not occupational therapy services were delivered without discrimination. So did they think that an equitable service was being provided?

Equity of Service Provision

This respondent expressed concern that the rejection of jobs with low status compounded the stigmatisation of certain groups in society.

CPSM3: There's a danger that the... mentally ill feel... that they're still being stigmatised... and the elderly, particularly in our culture... our culture which... unlike many other cultures is very... has a strong emphasis on self assertion. We're rather aggressive... against certain individuals... we think they're failures.

Others thought that it reflected the trend of other professional groups, a view expressed by this respondent.

CPSM2: Well I don't think it's only occupational therapists that are... most of them are very reluctant to work in areas like mentally elderly ill and you have to be a very special person to work with learning disabilities.

From this respondent's viewpoint, the problem should be addressed by practitioners themselves but especially by inspirational occupational therapists with leadership responsibility.

CPSM2: Some of it has to do with professionals themselves...erm...wanting to take the challenge of some of the... what are... still could be called Cinderella ... areas in health care...but a lot of it also has to do with the managers of those services...

... And I think... there are not as many... of the older, more mature, experienced professionals around... working where they can help to encourage and support younger professionals, particularly in... difficult areas of practice.

As far as CPSM were concerned, all of these respondents thought that occupational therapy was an altruistic profession but that the service ideal has changed over time. In their opinion, professions have become more self-interested but philanthropic intentions are still evident. There was some complacency about shortages of staff in low status areas of work: it was explained away as being part of a common trend and therefore intractable. In their view, practitioners are drawn to certain areas because of the associated glamour or the link to science. This rather contradicts the altruistic claim. In a wider sense, such an attitude confirms society's intolerance of the elderly, the mentally ill and so on. At least one respondent thought it regrettable that the moral aspect of health and social care has been diminished recently. The responsibility to counter such attitudes was placed on practitioners themselves and inspirational role models.

SUMMARY AND DISCUSSION

Larson (1977) thought that altruism within professional work has been undermined, whilst Moline (1986) suggested that society's expectation of and the professional's approximation to dedicated service has 'slipped a bit'. Nevertheless, in his opinion, the ideal of all-embracing, pastoral care for clients remains a necessary part of professionalism. Analysis of these data has revealed that some practitioners and all CPSM representatives thought occupational therapists were altruistic. This may be an idiosyncratic viewpoint. Most of the educators, the COT representatives and some practitioners were less inclined to make the same claim. Altruism was perceived to have disadvantages in the labour market where professions compete for remuneration and exclusivity of work. It was also suggested that total devotion to others is not sustainable for long and would shorten the length of time practitioners were able to work before falling, exhausted by the wayside.

Welfare service provision is now more likely to be provided through bureaucratic organisations such as the NHS, making authority and autonomy less achievable (Haug 1973). Nixon (2003) argued that too much emphasis on performance and outcome measures, characteristic of the NHS, has constrained the fostering of

altruism. The practitioners agreed with this view, arguing that increased throughput of patients, resource limitations and a lack of autonomy has meant that patient choice is restricted. Therapists are driven to control treatment and discharge by offering the 'quickest solution', which serves the state rather than the patient. There is a risk of re-defining occupational therapists as technicians, effectively de-professionalising them, should this continue. It is interesting to note the efforts made by the educators to embed the service ideal into students' understanding of occupational therapy. At least two practitioners emerged from their education believing that occupational therapy was altruistic but that view changed once they were in the workplace. In the past, professionals were criticised for assuming they knew best and for not paying any regard to the patients' perspective. From these practitioners' point of view, the age of bureaucratic accountability has meant that they cannot always put others first, even if they wanted to.

If occupational therapists were altruistic they would apply their skill to all areas of work and especially to areas of greatest need. The three most attractive (high status) areas of work, according to the practitioners, were paediatrics, neurology and hand trauma whilst the least attractive (low status) were the elderly, mentally ill and learning disabilities. A summary of information about patient contacts within the NHS occupational therapy services (Department of Health 2002-03b) showed that 73% of referrals came from consultants in trauma and orthopaedics, general medicine and geriatric medicine. In all age groups under 55 there were fewer than 10 episodes of occupational therapy care per 1000 population but it rose to 130 for ages 75-84 and 236 for ages 85 and over. So the vast majority of patients requiring occupational therapy are aged 75 upwards, categorising them as elderly, an area which has recruitment problems. The practitioners know that this sends out a message to the public that occupational therapists find care of the elderly uninteresting but that does not change their career choices. Whilst there are strategies in place to address this issue, the COT and CPSM representatives had little expectation that this attitude would change. There was a feeling within the educator's group that staff shortages were good for competition. All groups agreed that practitioners continue to find intrinsic value in glamorous jobs. The CPSM representative was correct in saying that because occupational therapists are not acting as advocates for the elderly and mentally ill, they are contributing to the stigmatisation of those people. Occupational therapists can be devoted, yes, and have a service ideal to some extent, but the rewards they look for are status and reputation; 'the moral reward of colleague esteem' as Larson (1977) put it. Therefore, they cannot be altruistic.

Still, the intrinsic value of the work was a theme found throughout the interviews. Time after time practitioners referred to satisfaction and enjoyment derived from performing their work well and assisting a positive outcome for the patient. The respondents from COT, the educators and CPSM all highlighted rewards that revolved around philanthropic intent. So, whilst the moral dimension may be difficult to apply in certain circumstances, a willingness to 'do good' remains a

part of professional life for occupational therapists. Nixon (2003) concluded that professionalism still has a moral dimension, which should not be ignored during education or throughout the professional life span. In essence he urged professionals to reclaim, what he called moral purposefulness, by which he meant to engage patients more, to learn and listen in order to exercise effective judgement: to be reflective in other words.

Foster & Wilding (2000) thought that the service ideal was one of a number of positive elements in professionalism, which may need to be re-appraised but should be nurtured rather than dismissed. A reaffirmation of the service ideal has the promise of accountability as well as trust, which is so important in the market for services. Martin et al (2002) argued that the erosion of 'high calling' damaged the social identity of doctors both in the UK and the USA. In response, the organisational bodies in both countries have tried to re-emphasise the moral rewards of the profession and the General Medical Council has presented UK medical schools with a list of attitudinal objectives that students must demonstrate by the time they graduate. They called for medical schools, hospitals and general practices to be portrayed as moral communities, prepared to transmit their cultural values to students and staff. Devotion to duty and putting the patient's interests first are stressed as the measure of success, rather than financial gain (Vastag 2001). Within this cohort of occupational therapists there was a group who were dedicated to the low status areas of work. When patients are saying 'You've put the light back into my life that I thought I'd lost', this is a demonstration of the service ideal at its best. Martin et al (2002) concluded that the most important way in which attitudes are transmitted to others is through teaching by example from exemplary role models. If the service ideal needs to be encouraged or emphasised, what better way than to use those who find working with the elderly desirable? They have shown that it is possible to have a positive self-image through their work and are embodiments of the moral ethic of occupational therapy.

But how can moral purposefulness be perpetrated? Occupational therapists undergo a period of adult socialisation, which begins during education. The next chapter will investigate the ways in which they are taught to abide by a code of ethics and a service ideal that necessitates high standards of behaviour, lifetime commitment and devotion to duty.

CHAPTER 9 - FINDINGS

Data showing the initial coding and categories for socialisation are presented in Appendix 11.

SOCIALISATION

Socialisation is the process of social interaction by which people adopt behaviours, beliefs, attitudes and values. Durkheim (1957) considered that to be socialised was synonymous with being civilised. Vander Zanden (1990) explained its origins, traced to the work of Charles Cooley and George Mead, who supposed that normative structures were integrated into the 'self' through the process. Interaction, conveyed through all forms of communication, is essential for individuals to be able to understand 'who they are'. Cooley developed the concept of the looking glass self, by which individuals' assume the stance of other people and view themselves, as they believe they are seen. There are three phases: we imagine how we appear to others, we imagine how others judge our appearance and finally, on the basis of those judgements, we develop an associated feeling such as pride. Mead further explored these ideas arguing that a sense of self is gained by individuals taking on a dual perspective, 'simultaneously we are the subject doing the viewing and the object being viewed' (Vander Zanden 1990). Goffman's (1969) work on impression management went on to demonstrate how individuals present themselves in a favourable light in order to have some control over what happens to them.

According to Berger & Luckmann (1966) socialisation begins with internalisation, the process through which an objective event is evaluated as meaningful. Primary socialisation occurs in childhood when parents and teachers act as intermediaries and mould their infants in the norms and mores of their own social world. Secondary socialisation happens as adults 'take over' the world in which others already live. It is the internalisation of institution-based 'sub-worlds' and is closely associated with the world of work. Elliott (1972) considered professional socialisation to be a historical legacy dating back to when the status and occupational professions gradually assimilated with each other. It was an attempt to maintain the social position, power and status of the former. Investing students during their long education with the ideology of service and professionalism unified them in believing that they were involved in a 'high' calling, giving them a sense of pride. Recruits emerge from professional education having internalised the idea that they belong to an esteemed group, believing themselves to be trustworthy because they have expertise in a specific area and bound by strict rules to behave with morality.

Close knit professional unity is all-important. Flexner (1915) described a profession as a 'brotherhood'. Greenwood's (1965) final attribute of a profession was a professional culture, which contained the norms of behaviour along with the associated language and symbols, all of which served to separate it as a

distinct group. Berger & Luckmann (1966) highlighted language as the most important vehicle by which the routine interpretations, taken for granted assumptions and conducts within an established world are conveyed. Tacit understandings are passed on through vocabularies that are specific to a work role. Terms such as 'my colleague' help to confirm the unity of an occupation (Moore 1970). Those who use the same language maintain the belief in the reality of their world. Only fellow occupational therapists, for example, are able to engage in conversations consisting of acronyms such as ADL (activities of daily living), or MOHO (model of human occupation). Terms like 'therapeutic use of self' have the same meaning for all occupational therapists whatever their work setting, helping to sustain the belief that this particular sub-world is real.

Symbols are another form of communication, which take many forms. Professional Associations, for example, striving to gain recognition, adopt conventional status symbols such as a capital city address, armorial bearings and royal patronage. Codes of ethics are also symbols. The service ideal, expressed through the code, communicates the idea that high standards of behaviour are guaranteed. Professional education is lengthy and difficult, to demonstrate intellectual skill. These symbols help to distinguish those who belong to an elite group and perpetuate the cultural understanding that the professional sub-world is somehow special.

Larson (1977) maintained that socialisation occurs in all occupations, not just the professions: the result being conformity and identification of people with work roles (chefs, firefighters and so on). So what is different about professional socialisation? Trust is the discriminating factor. It is argued that specific patterns of behaviour are necessary for professionals to ensure that they do not abuse their power (Elliott 1972). Patients/clients are vulnerable to exploitation and they will only divulge potentially embarrassing information to a professional who adheres to a high level of behavioural self-control, trustworthiness and confidentiality. For this to be internalised a more extensive socialisation than occurs in other occupations is necessary (Goode 1969; Barber 1963) and this requires a lengthy educational process.

Hughes (1981) saw socialisation as a cyclical process. The starting point is a student entering education with ideas based on lay culture. Through the education process, examinations and practical experience, the professional culture is imbued; and finally new professionals bring what has been learned into professional practice and also, through interacting with the public, into lay culture again. In this way the reality of the professional sub-world is maintained. According to Vander Zanden (1990) were it not for socialisation, the renewal of culture could not occur from one generation to the next.

Socialisation is not a straightforward process. The study by Becker et al (1961) of student culture in medical school discovered that a professional identity was not adopted until graduation and registration had symbolised legitimacy to do so.

When they entered medical school the students had idealistic ideas about healing the sick in an altruistic manner. Such thoughts were sidelined in the early years as they directed all of their effort to getting through examinations and gaining medical knowledge. They knowingly accepted the arduous process that lay ahead of them and expected to emerge as different people. Yet, despite this high motivation to change they did not become simply what the medical school wanted them to become. The school had some effect but so too did practical clinical experience and the role models they encountered. While they remained in education some perceived themselves as 'students' whilst others projected themselves forward into their future role and saw themselves as 'medical students' but it was made clear to them that they were not yet doctors. It was only after they graduated that they took on that role and the ideal of service was reaffirmed as part of their self-perception.

Socialisation provides status; it controls behaviour, ensures trustworthiness and supports the idea of lifetime commitment to a single career (Goode 1969; Johnson 1972; Freidson 1994). Institutional routine helps to make it effective (Berger & Luckmann 1966). Johnson's (1972) analysis showed that traditionally, professional education employed a uni-portal system of entry, in which entrants were of similar age and background and went through the same experiences in order to create unification of the socialisation process. Lengthy education housed in vocational schools, controlled by professional members, the creation of professional bodies, journals and interaction through conferences in which highly specialised language was used all helped to maintain the professional culture. However, introducing diversity into entry to universities carries potential problems with the socialisation process. The modern trend of using multi-portal systems, in which entrants are manifold and the delivery of education varied (including part time and remote learning courses) may, in fact, render the socialisation process inconsistent (Johnson 1972). Has this been the case for occupational therapists? The socialisation of practitioners was examined with the aim of establishing the nature of the process, the level of success and whether or not a pattern could be established. The following questions were posed.

- What did you know about OT before you trained?
- When you were a student, what direction did you see your OT career going? Did that change after you qualified?
- While you were training did you expect to have 'learned it all' by the time you qualified?
- Tell me about your fieldwork placements... how useful were they in expanding your clinical experience?

- Was there anyone you met during training who you thought of as a good role model? What were/would, be their qualities?
- Was there a point when you began to feel like an OT?
- Can you remember when you began to feel responsible for your patients?
- Can you pinpoint a time when you were able to explain something to a patient, confidently, in lay terms?
- As an OT, do you consider yourself to be a professional person?
- Would you ever consider leaving OT?

THE VIEWPOINT OF PRACTITIONERS

Occupational Therapy in Lay Culture

Unlike professions such as medicine or nursing, occupational therapy is little known in lay culture; there are only 23,000 registered in the UK (Council for the Professions Supplementary to Medicine 2002). In a study by Craik & Alderman (1998), around 30% of mature students stated that they were not aware of occupational therapy when they left school. Among the whole cohort in this study 40% knew 'very little' or 'absolutely nothing' about occupational therapy prior to making a career choice. Representations of occupational therapists in the media are scant and usually unflattering as this respondent recalled.

OT11 (mental health): The only OT that's ever turned up in a soap opera committed a gross professional misdemeanour and most probably would have been struck off so you know... it's not good. And the other time somebody else was an occupational therapist they were represented in the film as a physio.

For the more prominent professions it is the case that some people will know a relative or friend who is a member, whilst others may have been a recipient of the service. Awareness of their existence may then be relayed through these peoples' interactions with others and they remain part of lay culture. Whilst everyone has an idea of what a doctor does without necessarily having had a personal encounter with one, the same cannot be said of occupational therapists. In response to a decline in applications to health professions degree programmes the College of Occupational Therapists (COT), undertook a national survey to determine the factors that influenced an individual's decision to choose occupational therapy as a career. The report found that only 3% of students had immediate family who were occupational therapists (College of Occupational Therapists 2002). Craik & Zaccaria (2003) conducted a similar survey for a single university and their results showed a higher percentage (16%) of students who

had a family member or friend who was an occupational therapist. However, they found that students who had themselves, or someone close, received occupational therapy, accounted for only 9% of their cohort. Within this study, only one respondent's interest was inspired by chance interaction with occupational therapists.

OT9 (physical): I'm pretty typical I always knew what physio was but I didn't know what OT was erm my niece was in [a hospital] for a long time so she had an OT there which made me interested in OT. And then my aunt was on an elderly ward and I saw it again from a different aspect so that's what made me interested.

It is, therefore, no surprise that few people in this study knew much about occupational therapy initially. That being the case how did they find out about it? The College of Occupational Therapists (2002a) reported that 31% made the decision to pursue occupational therapy around the time of taking A Levels or Highers. Craik & Zaccaria (2003) ranked a school careers adviser or teacher a lowly sixth as a method of first hearing about occupational therapy. School career services were however a route used by some of these respondents: evidence that it has some viability in getting occupational therapy into the mainstream. Relatively few took up the opportunity to learn about it in school but the following quote gives an example.

OT7 (mental health): I'd actually done a three week Trident work placement in my fifth year at school, in a local rehab department and quite enjoyed it... went back in the sixth form to do voluntary work in the same department.

Eighty three percent of the group sought out information for themselves after hearing of it through a variety of means. The College of Occupational Therapists (2002a) reported that 81% of their survey respondents had spent time observing occupational therapy practice before they started their course. It suggests that students hear of the profession by chance and if inspired, make an effort to find out more. Craik & Zaccaria (2003) found that working in a health care setting was the highest ranked method of first hearing about occupational therapy with a figure of 25%. COT's study found that 30% had worked in paid employment with an occupational therapist. A smaller proportion of this study group (14%) was drawn into occupational therapy education as a result of having worked as an assistant or technical instructor. Often an interest was sparked because of the type of work going on or, as in the following example, through meeting a role model.

OT18 (mental health): I was working as an OT assistant and there were various OT's around me who sort of inspired me really... One in particular erm so I think I just used to ask her as we worked along... really and in meetings and when people sat around and talked about differences between OT's and nurses.

The COT survey found that 22% made the decision to pursue occupational therapy while studying for a first degree. Likewise, universities played a part in guiding career choice for this practitioner.

OT10 (community): I finished my [first] degree and I thought ok now what? ... And 'what' didn't come and so I thought right ok I've been drummed into thinking that education tends to precede a career so I got out the university prospectus and I flicked through and I saw physio and I thought no... And I saw OT and I read through it and I thought everything in my *life* that I have ever done has led me to... becoming an OT and I... it was like the penny dropping... Absolute certainty that that's what it was.

For others an initial interest in allied health professions was the stimulus: a factor ranked number five by Craik & Zaccaria (2003). As in the following quote, nursing and physiotherapy were commonly mentioned; testimony to them being better known in lay culture.

OT22 (Physical): I originally wanted to go into nursing but decided that... I wanted a little bit more... than nursing and it was either physio or OT. I wanted some kind of therapy... When I looked into it more I found out the information about OT and it appealed to me more and more.

Whether they arrive through the health and social care labour market or educational institutes, making occupational therapy education open to mature students has been provident. The report by COT suggests that most now enter the profession at a later stage in their lives. In response to their findings they planned a recruitment strategy to increase the number of applications to occupational therapy courses and to improve retention figures (College of Occupational Therapists 2002). The greater the number of occupational therapists in the labour market the more likely it is for them to take a greater part in lay culture. There seems to be an onus on practicing members to act as positive role models ready to inspire those with whom they interact. Evidence that occupational therapy is infiltrating lay culture, albeit slowly, is provided by the fact that this respondent's interest was stimulated following the suggestion of another person. The same factor was ranked third in Craik & Zaccaria's (2003) survey.

OT11 (mental health): I didn't know erm that OT's existed until a couple of my mates suggested that that might be a good career path to go down when I was really getting... pee'd off with being [in another occupation]. So OT was suggested then and I have friends who said you know, 'why don't you think of that?' So I did, simple as that but I wished I'd found it earlier.

Having heard of occupational therapy Craik & Zaccaria (2003) found that the factors, which were then important in the decision to pursue it as a career, included a chance to use creativity and the combination of craft and medicine. In

this study, some respondents' choice of career also began with an interest in crafts or activities. This section (28% of the group) includes recent graduates, suggesting that within the lay culture that does exist, the association of occupational therapy with craftwork is still active. For these people it was a positive association, as the following quote reveals.

OT5 (physical): I think one of the things that attracted me was that er... I quite liked the craftwork bit and I also like people so the sort of... mixing the two... appealed.

It is not insignificant that people are attracted into the profession at a later life stage when they have had more opportunity to encounter it. There are two scenarios to this trend; a) more students become interested in occupational therapy at A Level or Higher stage because it becomes generally more known or b) a perception develops in lay culture that occupational therapy is more suitable for the mature student. Whatever the case, given the effort required from all potential students of occupational therapy to find information, a range of strategies for attracting new members would be prudent. The findings of this study are consistent with those of the College of Occupational Therapists (2002a) and Craik & Zaccaria (2003). Interaction with an occupational therapist is a powerful tool but using career services, working in a healthcare setting, studying for a first degree and researching other allied health professions have proved successful routes to the profession.

The fact that students had little prior knowledge about their chosen profession could be advantageous in that they were starting from a relatively blank canvas on which to lay down secondary socialisation. One of the factors, open to being influenced during education was the direction that students took once qualified. What was the case for this cohort?

Career Direction

Elliott (1972) supposed that students entered education with a general idea about their future role but it was incumbent on the educators to steer them towards the career opportunities available to them in professional practice. Institutions have the power to direct students towards some opportunities and away from others. This could be a useful strategy to draw people into areas of most need, mental health for example. Doyle et al (1998) conducted a longitudinal study examining the factors that influenced occupational therapy students' preference of clinical area from pre-entry into education to post selection of the first job. They found that role models both in academic and clinical settings, plus interesting fieldwork placements had positive influences on the direction those students eventually took. Conversely, unsatisfactory experiences had a negative effect. Educators were urged to recognise their ability to influence students and the future of the practice of occupational therapy by channeling them into areas of most need.

Sixty one percent of practitioners reported that, when they started work as occupational therapists, it was in areas they could not have envisaged early in their education. Generally, the choice was made as a result of having developed a specific interest in the area. Only two reported that their choice was made because that was 'where the jobs were'. In some instances they began with fixed ideas but changed direction, as the range of possibilities became evident, often becoming quite passionate about their choice. This respondent for example, originally wanted to specialise in housing design.

OT34 (mental health): I've totally gone off that... erm... I think primarily because I'm much more interested in mental health rather than the design sort of... erm... That would bore me because... because I'd miss the hands on you know, sort of dealing with... the people I work with you know and I really enjoy sort of getting a bit of rapport going but being able to use treatment within that and... I'm fascinated I suppose with the mind.

Elliott (1972) argued that socialisation into a specific role does not change people; they are not passively being shaped into something they are not. Rather it extends their existing attitudes and patterns of behaviour. Therefore it is not unreasonable to expect some occupational therapists to have retained their direction of interest throughout their education. That was the case for 25% of the group. Either they had made the decision prior to entering university (two of the respondents continued in the direction from which they had started as occupational therapy assistants) or they developed leanings towards a specific area during the early part of their education. These people tended to look in the long-term towards a future role and focussed determinedly on that goal. The respondent in this quote had been pleasantly surprised when other clinical areas were encountered but remained focussed on mental health.

OT35 (mental health): Oh I'd always gone in... into college with the view of tolerating the physical training in order to gain mental health training... and I'm very glad to say and I can say in all honesty that I enjoyed the physical a lot more than I expected.

According to Elliott (1972), socialisation involves learning to be what one already is (a student) as well as being about a future role. Fourteen percent of practitioners took a short-range view and simply wanted to qualify. Partly this was due to a general interest in all aspects of occupational therapy and a willingness to look for opportunities as they arose but they also seem to have identified themselves as 'students' rather than future occupational therapists.

OT15 (physical): I don't think I really thought about my career to be honest when I was a student. All you think about is qualifying and getting your first job so I never really thought this is where I see myself going. I didn't have a long-term plan.

In brief, the majority of practitioners changed their preference of work setting during the course of their education or first job. There was a core of people who stuck with their initial ambitions despite being exposed to the value of other opportunities. For a small percentage the primary aim was simply to qualify. A literature search conducted by Doyle et al (1998) revealed several pieces of work which had examined the influences on students' choice of work setting, all concluding that academic coursework, clinical fieldwork and selection of the first job were the main factors. The results from this study are consistent with these findings. However, four practitioners (11%) had moved their direction of interest away from mental health. Doyle et al's (1998) study revealed that at the end of academic coursework only 12% had changed their preference in favour of mental health in comparison to 29% who had moved to physical health. Occupational therapy education therefore does influence students' direction of interest but it behoves the institutes to examine the ways in which those interests can be stimulated so that they are geared towards serving areas of greatest need.

Where preferences had changed, fieldwork placements had been influential but in what ways?

Fieldwork Placements

Elliott (1972) identified two distinct strands of socialisation; role socialisation consisting of training in the skills of the job and status socialisation in which the social identity and patterns of behaviour necessary for the future status position were acquired. Occupational professions emphasise role socialisation through some form of apprenticeship outside of the education institute, clinical experience of doctors or fieldwork placements for occupational therapists, for example. Holland (1999) studied the transition from student to qualified nurse in the light of the work of the anthropologist Arnold Van Gennep. Practical clinical work was considered a critical event leading them to take on the identity of 'nurse'. They went through a process of change. Becker et al's (1961) study revealed that medical students expected to be changed in order to take on the role of doctor. Perhaps 'moulded' might be a better description, given Elliott's opinion: the underlying personality remains the same. But again clinical experience was considered to be the most effective way of learning the components of that role. Likewise, fieldwork placements and in particular the quality of supervision received are considered to be important components of occupational therapy education (Bonello 2001). How are occupational therapists moulded and how are they different from the point of entry into education to graduation?

Holland (1999) found that as students entered into nurse education they brought with them the notion of 'vocation' from lay culture. Lay culture holds the belief that education for a profession involves teaching them everything they need to know. Although most of these respondents changed their opinion eventually, 53% came into occupational therapy education believing that by the end of it they would have all the skills necessary for the role of occupational therapist. This common view is expressed in the following quote.

OT16 (mental health): I sort of had this vision I would come out as a... as an all rounded OT even if I didn't know everything I would have skills in every area... of the spectrum.

This was their preconceived lay culture belief. As the course progressed most people detached from this notion and arrived at the conclusion that they were unlikely to know it all. This was especially the case for university graduates where the academic bias is aimed at how to learn rather than being specific to professional skills, as this practitioner highlighted.

OT12 (mental health): I don't think anyone will know all there is to know... but I feel that I've come out with the ability to reflect on what I'm learning and just being able to do that. So instead of a bearer of knowledge I'm kind of... a continuous learner... by reflecting on what I'm doing and knowing how to keep doing that learning.

Hughes (1981) believed that socialisation was in part, about learning the techniques of playing the role well. The fieldwork experiences of this group were examined to explore how the socialisation process had been enacted and whether or not it had influenced the way that these occupational therapists had learned to play the role. Some respondents found that they began to gain confidence in their ability to take on the future role of occupational therapist, despite any difficulties they might have had in 'being a student', a point made in the following quote.

OT21 (community): I settled in very quickly on my placements even though I did always lack confidence as a student. You really feel you are a student but I think towards my third year... I got into it very quickly and I really, really enjoyed them and thought 'yes I can do this', you know... I'm not doing bad, I might struggle with the paper stuff but I'm doing really well with this... it came very easy to me yes.

Fifty eight percent reported that fieldwork placements were crucial for developing an understanding of both the concept and scope of occupational therapy. They experienced a range of clinical conditions, discovered personal preferences, had the opportunity to practice clinical skills in 'real situations' and gained confidence. Throughout, there were examples that these experiences brought about an adjustment in self-perception. For this respondent, the idealism created within the university culture was replaced by realism.

OT1 (physical): They [fieldwork placements] were useful, they gave me insight into... almost real world and... dropping my idealistic sort of views and me wanting to solve everything.

Preconceptions were challenged and change was generated. Some had preconceived negative expectations of a placement but were pleasantly surprised and ended up working in that setting. Others had not fully understood the

significance of what they were being taught in the educational institute and did not believe that it would work in the clinical field until they saw it in practice, when it then became 'real', as this respondent explained.

OT10 (community): Understanding the OT process **can** be used across the board... and *knowing* that because I was able to put it into practice and it worked! It was real and it did work, they were right... they weren't telling porkies [laughter] they were telling me the truth and it worked... so yeah I think the fieldwork experience was **crucial**.

Some were able to make discriminations in their perception of what does and does not constitute occupational therapy. It helped this practitioner to identify an acceptable definition of the profession.

OT34 (mental health): The first fieldwork placement I had was elderly psychiatry erm and that wasn't... it was very interesting and it got me into group work and some of the conditions etc but it wasn't really... OT as such it was [entertainment] so from that perspective it was useful and not useful... erm... My second year, I had two placements in the second year, one was... erm social services erm over 65's in the community which I think was very, very useful in that it made me think 'I am never going to do this as an OT'. Because although we were going out to homes and we were... assessing *certain* things but a lot of it I thought was...[just dishing out things]. We were just... we had lost the sort of purposefulness of it... but it was really healthy for me because it made me totally question what I was doing and my supervisor was great and I had really good discussions with him.

Twenty two percent highlighted skills that were learned on fieldwork placements. Many, including this practitioner, referred to the way that they were allowed to practice clinical decision making, in a controlled manner.

OT4 (physical): In the second year it was social services... you were sort of left... there I feel I gained a lot... confidence and skills because you're on your own... totally. And I think that gives you... a lot of experience because you're having to think on your feet... how do I deal with that... and you come back and have a supervision session and you know, hopefully you got it right.

Tompson & Ryan (1996) found that student occupational therapists learned most of their professional language: how to communicate with patients, how to produce written reports and how to communicate with other health care workers, during fieldwork placements. They likened it to learning a foreign language. This group expressed the same ideas, for example,

OT15 (physical): What you learn is... erm... how... you get confident in your own interactions with other people and I think that's one of the main things... perhaps...(3)... You learn to organise your time I think... that's something I learned from mine... And you learn to plan erm... yeah, you're in a situation where you have to be able to... feedback information in front of a group of other professionals... and that's very important to be able to do that erm and to express sometimes an opinion about something that's very important.

Appropriate body language was also learned, internalised and then instilled in others. This respondent described how behaviour that had been learned on fieldwork placement was now being perpetuated.

OT1 (physical): If I'm on a ward round I like to be erm... this drives me mad but I can't stand hands in pockets...I can't have hands in pockets and none of my basic grades do. They go mad at me when I tell them this [laughter] you know and hate it... really... Hands in pockets and chatting or being you know... always... I think certain things like having your hair tied back and whatever so [you're] being professional... really so you're actually taken seriously...

Secondary socialisation can prove difficult and its tenets open to challenge because it is superimposed on the primary, which tends to persist. Tompson & Ryan (1996) for example, described how student occupational therapists found social distance difficult to learn because they had an inherent desire to demonstrate concern to patients. They also needed to accustom themselves towards handling the human body in ways that would have been considered inappropriate in their preceding environment. The following quote suggests that this was the case for many of these respondents.

OT15 (physical): I think you learn to handle patients because certainly I came from a background where I never really had the... not touching of other people and initially that's whoa! [chuckle] You're a bit hands off aren't you and then... so it gives you the confidence to be able to handle and touch people and you learn quite a lot of non-verbal communication as well.

Thirty one percent of respondents thought that fieldwork placements were the most important aspect of their education. Largely this was attributed to the role models that were encountered, a view expressed in this quote.

OT18 (mental health): Whilst I was training I used to get very excited when I went on placements even though they were terrifying as well. But to me it was the most satisfying way of learning... generally because, you know, you could put theory into practice all the time. And you could learn

far more by being with a... with a... efficient or effective OT than you could just reading a book.

The practitioners brought with them, into occupational therapy education, a lay perception that they would emerge 'knowing it all'. That changed quickly, especially for graduates. Fieldwork education was regarded as integral to this change and an important place to try out a future role. It helped form a self-perception of the type of work, personal preferences were identified, they saw how occupational therapy worked in practice and it allowed them to create their own definition. They also learned the behaviours, language and attitudes required for their role. Since role models played an important part they were investigated further in order to establish what qualities were being emulated.

Role Models

Socialisation in later life does not require identification with significant others, in the same way as it does in childhood, but it does need people to represent institutionally specific meanings (Berger & Luckmann 1966). For example, fieldwork supervisors, with knowledge specific to the provision of occupational therapy in health and social care institutions, fulfil this role. The significance of fieldwork supervisors in the socialisation process of student occupational therapists has been noted (Bonello 2001). According to Berger & Luckman's explanation the knowledge taught by one supervisor is specific to occupational therapy as a whole and could be taught by any supervisor. However, individual supervisors may be subjectively differentiated in a number of ways: as good or bad for example. Hummell & Koelmeyer (1999) found the transition from student to practitioner was helped or hindered depending on whether or not good role models were encountered. Whilst a few people mentioned a tutor or a colleague, 83% of these respondents, when asked to think of a good role model during their education, chose a fieldwork supervisor. So what were their qualities?

Good teaching skills were important, particularly the ability to facilitate a student's capacity to learn. It was the articulation of clinical reasoning and the passing on of advice gleaned from experience that was pertinent to this respondent. What was learned in this instance was behaviour that could anticipate and therefore avoid problems that might arise in the future.

OT12 (mental health): My supervisor in my third year placement who was a Senior I in learning disabilities was absolutely brilliant and I think she made me... well not made me but she helped me become the person that I am now. She made me talk through all my clinical reasoning and reflect and reflect and reflect which... and planning, the ability to plan things, about planning things down to the finest detail, how you can prevent, kind of, things going wrong.

Expertise was valued as being closely allied to professionalism, a point made in the following quote.

OT28 (community): The first thing that came to mind then was that they were very professional people erm they... people that clearly knew what they were talking about, they knew what they were doing.

Moore (1970) argued that one of the most effective ways of internalising socialisation was shared memory of going through serious trials during education. Where a supervisor demonstrated high standards of work, people were prepared to endure difficult times in order to absorb the same type of behaviour. The inference made in this characteristic quote was that expert knowledge would result in high esteem.

OT11 (mental health): One of the OT's who... wasn't my supervisor but had this expectation that I would know the ins and outs of the human book, you know and I thought Christ! But... inspiration! ... I thought... this is what I've got to do I'm going to really make sure I know my stuff you know because I felt so *small* you know... I don't know those joints.

Reliability and diligence were qualities noted but more often than not, it was the intangible nuances that were most significant. Many people mentioned that they admired selfless, beneficent behaviour, a view expressed by this practitioner.

OT16 (mental health): All my supervisors were excellent...(4)...they just seemed to be... what I envisaged OT's should be really... They were quiet, they were calm, organised... patients liked them, patients seemed able to relate to them... explain what they needed. Went about it... did what the patients wanted without flapping and big show of things saying, 'Aren't I wonderful I'm doing this for you?' They just... quietly got on and improved peoples' lives really.

The ability to make patients feel that the therapist was showing interest and that their problems were being taken seriously, was illuminated by this practitioner.

OT21 (community): I think it was just... her approach to patients. Everybody was very individual and she tried to give everybody the time to go through all the different problems at home and she really got to know them and develop a relationship with them and I really... That's why I admired her... she just had time... she was interested in them... they weren't just another patient.

The ability to interact warmly with patients from all sorts of backgrounds and with conditions that might make communication difficult was universally admired, an opinion expressed in the following extract.

OT35 (mental health): I was impressed with a senior 2 on the mental health placements... who I felt could relate with the patients... very comfortably, very easily... could actually change her approach... subtly and appropriately.

For this practitioner, a sense of humour, whilst still retaining professionalism, was important.

OT23 (physical): They all had a sense of humour... and none... I don't think any of them took... they took things seriously obviously it was their job but they didn't... er run around flapping erm they were just... coped with it... They were pleasant about it and could have a laugh with us as well.

Respondents were inspired by and wanted to emulate supervisors who demonstrated a strong role identity. This practitioner explained the importance of this.

OT8 (physical): I really felt that I could trust them and I really *believed* in them as an OT.

All of these attributes embodied the ideal occupational therapist for these respondents and brought the sub-world to life. This type of 'bringing it home' is significant for secondary socialisation because the behaviour has been instilled to a depth akin to that of primary. This practitioner summed it up.

OT20 (physical): I'd think yes... this is the sort of OT I'd like to be.

Twenty two percent of respondents also had at least one negative fieldwork experience. When difficulties with a supervisor were encountered various coping strategies were employed. Some respondents, for example, chose to adhere to their own concept of occupational therapy learned from previous work experience or at university. This practitioner, sent to a forensic psychiatry unit, used technicians as role models rather than the allocated supervisor.

OT21 (community): It was great having two technicians... the supervisor wasn't up to much... actually I complained about her but the technician was fantastic. He got me through my placement, you know... I quite enjoyed that. I didn't really get to do a lot of OT because I was forever being locked in the office and I didn't have any keys for three weeks. I couldn't move around freely and there were only certain times that you could move around because they were all quite dangerous people so you needed to be escorted everywhere. So it was very difficult to... sit down and do... occupational therapy activities. The only time I did it was with the technician in his workshop. We did quite a lot of woodwork and candle making and I really, really enjoyed them and got such pleasure out of these guys... I mean one guy murdered his mum and his dad but... I

got beyond all that and got to know the person and they all had some good qualities about them.

Under these circumstances, if change occurred, it was in terms of marking how not to behave in the future. Mostly though, fieldwork education was seen in a positive light. Students learn practical skills during fieldwork education, of course, but the thing that the respondents remembered most clearly was learning the attitudes, mores, language and behaviours that are composite for the role. This respondent hit the nail on the head.

OT15 (physical): I don't personally remember learning an awful lot about... clinically it was more about... my behaviour erm how I conducted myself.

Socialisation does not however, stop once education ends but continues into professional life (Elliott 1972). The first work experience where, typically, people are employed on rotational schemes spending a few months in different areas, can prove influential in the transition from student to practitioner occupational therapist but in what ways?

Role Transition

The transition into a professionally qualified occupational therapist does not happen suddenly and for some it can be problematic. In an Australian study Sutton & Griffin (2000) found that new practitioners had difficulties with their first work experiences and were often dissatisfied. Rugg (1999) found that factors that might result in withdrawal from practice included problems adjusting to early practice and uncertainty about professional identity and role. Some of the respondents in this study were not confident in their role when they first graduated, as the following quote reveals.

OT1 (physical): I almost think I carry out OT skills and OT tasks but a whole OT is something I'm not.

Some studies concerning the role transition of healthcare professionals have considered the issue in terms of a timeframe. Hummell & Koelmeyer (1999) for example, concluded that it took six months for occupational therapists to adopt a professional identity. Barnitt & Salmond (2000) also considered that the first six months were important and they suggested that the first year should take the form of preceptorship. They reported that new practitioners saw themselves as 'graduates' rather than occupational therapists, which was a concern because they were more interested in what the job could do for their career rather than their contribution to the workplace. Holland (1999) and Tryssengar (1999) took a more phenomenological approach and identified a series of phases that practitioners went through. Kasar & Muscari (1999) proposed an eight-stage model for the development of professional behaviours in occupational therapists as they made

career progression. Advancement was facilitated as practitioners confronted a series of conflicts. Role identity occurred at stage five, after a post-graduate, novice stage. The indication is that internalisation of self-perception, as an occupational therapist is a slow and complex process.

The entire group in this study had accepted their role identity at the time they were interviewed so how had the transition from student to qualified occupational therapist occurred? Some people (14%) had internalised the identity of an occupational therapist whilst a student. Others located it at some point of time after graduation, which varied from six months (14%) to 18 months (8%). Yet for others it was the first job (14%) or first senior position (25%) or a specific incident (22%). All of this needed teasing out to get to the finer detail.

Fourteen percent of practitioners reported that they felt like an occupational therapist whilst attending university. Hughes (1981) considered that a person's conception of him/herself is itself something of a stereotype, to which parents, teachers, siblings, peers, and his/her own dreams have contributed. Some people project themselves far into the future; others operate more or less in the present. This respondent, for example, went through education firmly sighted on the future goal of becoming an occupational therapist.

OT32 (community): I felt I *knew* where I wanted to be and where I wanted to go... I knew what I had to do... it was just getting there... and I think I felt like an OT since I started.

Hughes (1981) thought that the period of transition into a role was one where the two cultures, lay and professional, interacted within the individual. In the process of change from one role to another there are occasions in which a person identifies with the role, but is not accepted in it by others. This respondent qualified just as mental health services were being re-directed into the community. Many occupational therapy assistants were embedded in institutional mental healthcare and found it difficult to cope with the changes. The transition into qualification was made particularly difficult for this person: a new graduate trying to get assistants, who had lengthy experience and had probably 'seen it all before', to work with the new ideas.

OT11 (mental health): I suppose my OT'ness has been challenged in the initial few years I was working in a closing down psychiatric unit and there were loads and loads of things... 'You people getting them out in the community, won't do them any good and they're all going to go bonkers out there and going mayhem'. And stuff like that and you were coming out... you a fresher from college and they were... they'd been there thirty, forty, fifty years you know erm and there was an incredible collision of cultures.

There are also occasions when other people expect an individual to play the new role before the person feels ready to carry it out. This was commonly the case just at the point of becoming qualified as an occupational therapist. A revision was necessary as the individual adjusted to no longer being a student whilst not feeling ready to behave in the way that others were expecting, a point made in the following quote.

OT28 (community): I remember when I first qualified erm just feeling so frightened really about going up on the wards erm and thinking people are going to think that I know what I'm talking about because I've got a uniform on.

This was also the case as people went up the ranks, as this practitioner explained.

OT35 (mental health): You're expected to be a senior 2 and the Friday before you were still a basic grade and it **does** take a while.

Whatever the case, revision or adjustment of self-perception was required. These people had no choice but to accept that the lay culture that they brought with them as students entering university had to be finally put to rest as they adopted the new role of occupational therapist. It does take time for practitioners in a new position to fully accept themselves into that role. The ways in which others behave towards an individual can confirm that self-perception. To treat an individual in a senior position, as an authoritative person is a 'significant reality-confirmation' to use Berger & Luckmann's (1966: page171) term: an indication that others share the same understanding of the situation as oneself. It takes time for others to accept someone in a new role but finally, everything slots into place, as this practitioner found.

OT22 (physical): I've noticed a big difference from being a student to being a newly qualified basic grade... people have started to take notice of me.

Another marking point early in a career was noted when practitioners were allowed to work autonomously and realised that supervision was different to that received as a student. This type of incident was common for these respondents. Despite some anxiety this practitioner was proud when, shortly after qualification, another professional behaved in a way that confirmed a transition had occurred and the interaction had taken place with an occupational therapist (the respondent).

OT23 (physical): During my second week when I first qualified at work... I think I'd done... some assessment with a patient and a social worker said to me 'in your professional opinion is this patient safe to go home?'... Usually you just say let me go and check with my supervisor and that really, really put me on the spot and I thought 'what on earth am I

going to say?’ But then I managed to say ‘well I just need to do a few more assessments and I’ll get back to you’. So I was able to think about it and speak to somebody else... and just clarify... that I’d done everything right [chuckle].

Strauss (1971) spoke of the conceptual changes, which occur throughout adulthood, as individuals evaluate events, acts and objects leading to transformation of the perception of self. Some transformations of identity are planned and symbolised in some way: the award of a degree for example, marking the change from under to post-graduate, emphasising the difference in self-perception between ‘before and after’. The change from student to qualified occupational therapist could strike home quite forcibly for some, as in this case.

OT13 (community): I don’t know, it’s weird it suddenly hits you that you... you know I came here and I was an OT!

Acquiring the first job would then confirm the transition from student to occupational therapist. This was a planned occasion reported by 56% of respondents where it made them feel like an occupational therapist, willing to accept clinical responsibility. For those who had previously worked as assistants it marked the realisation that no longer would they be able to avoid being responsible for patients, a point made in the following quote.

OT25 (community): I think probably just before I qualified I began to feel quite frightened of the fact that I was going to be responsible because as an assistant it was overseen.

Then there was a career structure to follow, marking progress from junior to senior therapist and acceptance of greater responsibility. For this practitioner the job titles were significant.

OT10 (community): Basic grade reminds you that you’re basic... and therefore you don’t really carry... have much accountability and responsibility... I suppose again it was the word senior... basic and senior suddenly seemed much more important than basic... so I suppose yeah when I became senior 2... and again my [manager] changed and... because she believed I could do it I did it and I took on responsibility.

Other transformations happen when a critical incident occurs, which causes individuals to recognise that a milestone has been reached and they are in some way different to the way they used to be. Strauss called these ‘turning points for self-conception’. The same kinds of incidents are likely to happen and be equally significant to others in the same occupation and so the development of personal identity forms a pattern. Turning points can be quite small such as being allowed to use professional symbols: uniforms, specific equipment and so on. This respondent even used the appropriate terminology.

OT18 (mental health): I think it was a turning point when I actually did my first physical placement and when I was whizzing around in green trousers and tunic and all the rest of it, badges and a goniometre in one pocket... I think that's when I thought yes I can be an all rounded OT.

Other instances highlighted the fact that knowledge had been acquired. Clinical experience accumulates slowly and goes almost unnoticed until something occurs to make individuals' realise that they have gained a large amount of knowledge. Many respondents could recall a time when they were ill equipped to deal with patients' questions and yet at the time of being interviewed they had reached a position where they could do so easily. The transitional stages were something of a blur and it was only when they looked back that they could see the change. This respondent was reflecting on the early days of clinical practice and coping with difficult questions from patients.

OT11 (mental health): If they'd said, 'ah but what if?' I would have been stuck... and I think now you know... ten years on I can sort of ad hoc... bang on about most of the issues that my clients or their carers are going to raise.

For this respondent a chance to make a comparison with others at the same career stage was telling. Regarding the others as 'students' revealed the gulf between the two positions. Note the use of 'my colleague', emphasising identity with a professional community.

OT15 (physical): I think the most telling moment once I qualified... because I went straight to work in community... another basic grade started at the same time as me... and we were invited to the [hospital] support group. And we went in there full of OT's and we'd been there since August and this was October and they said, 'have you done any home visits on your own yet?' And my colleague and I looked at each other and we said 'that's what we do every day' [laughter] and I sort of thought maybe... because they seemed so much like students.

A curious quirk for healthcare professionals is that having learned complex and jargonistic language as part of the socialisation process they then had to be able to communicate plainly and effectively with their patients. Eraut (1994) highlighted the need for professionals to understand what information was relevant to the patient and the importance of communicating it in an easily understood manner. The ability to turn a complex issue into language that a patient would understand is another turning point. Some respondents could recall specific occasions that made them recognise that they had become skilled in the art of communicating at different levels. For example,

OT29 (physical): Patient with head injuries... explaining to the relatives what's happened psychologically when they were saying 'oh look she can

walk now'... explaining that. I was quite pleased with the way I tackled it because... I had to do it very differently for the patient and for the relatives because they were not completely sure. She's had a car crash, her fiancée died in it, the whole wealth of it, she's had an accident and the bereavement process as well and it was trying to explain that whole process

Sometimes critical incidences can be literally 'crises'. Another rite of passage highlighting the acceptance of clinical responsibility was receiving a complaint, for example.












OT15 (physical): I think when you get your first complaint... working in social services it's like...[fairly common]... you think 'oh right'... because then you realise that nobody else is going to come in and mop it all up for you.

This practitioner suddenly realised that there was no choice in this situation, as a responsible professional, but to get a patient to hospital for her own safety.

OT32 (community): I literally carried her out... it was on a home visit... she was completely out of it... and she just laid down in front of the fire... in front of the hearth and wouldn't shift, she wouldn't budge.

All of these events and the individual's reaction to them form a pattern that most occupational therapists would recognise. It was certainly evocative of my own experience and gave me the opportunity to be reflexive in this particular aspect of data generation. I reflected on my experience and could recall many similar events to those described by the participants. I remembered being frightened on my first day at work, feeling that someone would ask a question that I could not answer. I battled with jargon, struggled to get patients to engage with an intervention and had to learn to cope with incidences such as people having heart attacks whilst in my care. Gradually, I accumulated experience and now when I look back I can see that whilst at one stage I was a 'novice' I have now come to regard myself as 'competent' and even 'expert' at much of what I do. My analysis suggested that this process matched the participants' experiences so well that it could be used to organise the data set. Therefore I decided to examine the participants' narratives along with my own and could see a similar developmental process. Using my reflexive account and combining it with that of the participants I was able to construct a more collectively applicable account of how professional identity might be acquired. I developed a continuum of the types of event that might be reflective of most occupational therapists' experience. I presented it to a few colleagues who verified that it was an authentic representation of their process too. The following diagram (see Table 10) thus offers a schematic description of how an individual's journey towards accepting the identity of occupational therapist might be plotted.

Table 10: Turning Points towards Accepting Professional Identity

TURNING POINT	RESPONSE
Award of degree 	Hooray!
A few minutes after award of degree 	Help!
First job 	I'm supposed to know what to do?
Patient asks who you are 	You give your name
The staff room is full of jargonistic banter 	It's a foreign language
A colleague asks you an OT related question 	Are you talking to me?
Your manager says 'It's too early to ask you to do this' 	Phew!
A patient says 'I didn't understand that doctor' 	Me neither
A patient refuses to do what you ask 	That patient is difficult!
A patient asks whether you can help with a problem 	Maybe
A colleague speaks in acronyms 	You understand
A patient asks you to explain the diagnosis	You translate it into plain language

A patient has an epileptic fit whilst in your care



You cope surprisingly well

Your manager says 'It's too early to ask you to do this'



I can cope!

A colleague wants to discuss a problem



You contribute several ideas

A patient refuses to do what you ask



I'll find a way

A student gets into difficulties



You sort it out

A patient has an epileptic fit in the care of a junior



That happened to me once!

A colleague seeks you out for the benefit of your experience



No problem

A patient asks who you are



I'm an occupational therapist

What do you feel?

Pride

These elements, drawn from experiences lived over time, have shown that through socialisation, a range of tacit values and beliefs came to be adopted but it is an individual process and whilst some will identify with the profession during education, for others it can happen after several years of experience. Nevertheless the interviews indicated that all of the practitioners had achieved some level of professional identity with associated feelings of high esteem and pride. Professional identity, Higgs et al (2004) argue is achieved as individuals develop an understanding of the meaning they attribute to practice, a shared understanding of suitable action to take in a given case and understanding of the boundaries of knowledge within which competence can be recognised. They suggest that it is also important to note that this happens in a working practice culture. Practitioners are socialised into knowing how to behave within the boundaries of their departmental routines and practices. They integrate their procedural and propositional knowledge with experiential knowledge gained from their work with patients. In addition, the perceived recognition of certain aspects of the work by others is influential in attributing meaning. This interplay of dimensions indicates that knowledge is appropriated by cross-meshing or 'scaffolding' rather than developing incrementally (Higgs et al 2004). This is what seems to have happened for these practitioners. They encountered experiences, sometimes prosaic, sometimes more dramatic. Their actions in response became more sophisticated over time but the realisation that they had acquired 'experience' occurred after a process of reflection as people looked back and recalled the events that had happened to them. These practitioners developed confidence in their professional role having coped with events common to their expectation of what a professional should be able to cope with. As this process continues and they manage more situations successfully they are more inclined to identify with that role.

The detail may change for individuals but the end result is that the respondents have been socialised in particular ways and have internalised the identity of occupational therapist. But has this extended as far as instilling lifelong commitment to the profession?

Lifetime Commitment

Most social analysts supposed that the heavy investment of time, energy and money had the benefit of insuring people would stay in the profession in the long term and would produce a strong identification of the person with the role (Larson 1977). Wright (2001) investigated the factors that influenced occupational therapists' commitment to the profession. She found that the newly qualified were more interested in skill consolidation and did not have long term career plans. When asked to project their careers forward five to ten years they were unsure whether or not they would remain in the profession. Senior occupational therapists on the other hand, had fully internalised the values of the profession to the extent that being an occupational therapist was an integral part of their self-perception. Her findings confirmed the idea that socialisation, which

continued into the workplace, was necessary for lifetime commitment to a profession. The situation was less clear cut for these practitioners.

Thirty six percent were committed to a lifetime of working as an occupational therapist, tending to cite the high level of job satisfaction they experienced, as the following quote reveals.

OT33 (community): I love this job too much... I think it's the best job in the world... to be honest with you.

Disillusionment and boredom were cited as the main reasons that would drive 33% of respondents to leave the profession. The characteristic view, reflected in the following quote, was that this was most likely to occur when bureaucratic systems placed restraints on an individual's ability to perform the job well.

OT31 (community): There have been times... probably quite a lot of times when I've really dropped to rock bottom, when I've thought 'I'm giving this all I can give it... and I'm still not getting anywhere'. And I'm not able to do the things I want to do because it's moving away from spending time with people. And if I'm *forced* to turn over a certain number of visits, if I'm *forced* to close cases, if I'm *forced* not to be able to visit people... that I have to deal with it over the phone... then I don't want to do that.

Among those who might consider leaving the profession at some point (30%), the reason given was that other challenges and new opportunities might present themselves. This practitioner, for example, has adopted the culture, which upholds the idea that jobs are no longer for life and it is to be expected that people will have several career changes.

OT16 (mental health): I've always fancied more OT... well jobs where I could use my OT skills... but perhaps not as an OT. Managing children's homes, something like that... where you could use everything you've learnt as an OT but not actually practice as an OT.

Other careers that people considered were many and varied including horticultural therapist, play therapist, and medicine, managing an old people's home, project management, managing an outdoor education centre and sculptor.

The practitioners had all taken on the role identity of occupational therapist and virtually all considered themselves to be professional people. Yet, 33% thought that they would leave the profession at some stage, 30% considered it as a possibility, with only the remaining 36% reporting that they would never do so. Of the 23 respondents who had not embodied the idea of lifetime commitment, 19 were in senior or head positions, so there was no explanation to be found in the notion that they were still internalising role identity. It must be assumed

therefore, that this particular part of the socialisation process had failed for 63% of these respondents.

To summarise the practitioners' views, socialisation did form a particular pattern. Some aspects were planned but other elements were unpredictable; the type of fieldwork experience (good or bad), the unique contribution of the role models, the circumstances of critical incidences and so on. But generally, they emerged with common values, which, in the process of their work, they were putting back into lay culture. Traditionally, significant people have been used to advertise a profession and symbolise the stereotypical attitudes to be portrayed to the public (Elliott 1972). They may be drawn from lay culture or specifically from professional history (Florence Nightingale). Occupational therapy does have heroes and heroines but they are neither well known among the general public nor among occupational therapists unless someone has a particular interest in history. The most effective way to integrate occupational therapy into culture is through interaction with role models. Their importance cannot be over stressed.

Once students have entered education the socialisation process begins, one of its effects being on career direction. Universities, fieldwork experiences and role models open a range of possibilities or can confirm a student's original intentions. There is potential for this to be geared towards matching the requirements of society. From the point of entry into education towards graduation and beyond the respondents were internalising the identity of an occupational therapist. Fieldwork was key to the process. They developed an understanding of the concept of occupational therapy whilst the reality of the sub-world was brought home. They learned professional skills and through role models they absorbed the attitudes and behaviours that were necessary to survive in this world of choreographed interactions. Adjustments and revisions to self-perception went on continuously as objective events occurred. The process was gradual but transformation was noted not only by the award of a degree but the ways in which others behaved to an individual and through critical incidences that caused a realisation that change had occurred. Socialisation continued into the workplace where once again role models were important. Rappolt & Tassone (2002) studied the ways in which physiotherapists and occupational therapists assimilated new knowledge during their careers. They found that most new learning was gathered from colleagues, as it was considered more realistic. They argued however, that this was a cause for concern since it was accepted at face value without the benefit of researching for evidence. This may be true of concrete knowledge but it could be argued that the importance of role model colleagues imparting what amounts to 'experience' should not be underestimated.

There has been an assumption that an outcome of socialisation would be lifetime commitment to the profession. This no longer seems to be the case, with many people anticipating several changes throughout their working lives. In the case of these occupational therapists it could partly be attributed to them wanting to explore other opportunities. But 33% expressing disillusionment and boredom is

a high percentage. Rugg (1999), examining attrition reasons for occupational therapists found dissatisfaction with bureaucracy encountered at work, unrealistically high caseloads, lack of professional status and lack of respect from colleagues to be important factors. Whilst little can be done about individuals' wanting a portfolio career, the root causes for dissatisfaction can be addressed. The College of Occupational Therapists (COT) is already involved in improving recruitment and retention of staff but what is the organisational body's stance on socialisation as a way of influencing members?

THE VIEWPOINT OF the COLLEGE of OCCUPATIONAL THERAPISTS

Although Larson (1977) thought that organisational bodies could influence socialisation, according to Johnson (1972), when professions are regulated by the state, the socialisation function of the professional association becomes less important, especially if trade union activity is adopted. When asked about the nature of the image that they wanted a socialised occupational therapist to portray to society the COT representatives were in alignment to the practitioners. Expertise, safe and patient focussed practice, treating people with respect, appropriate body language, good communication, and listening skills, warmth, empathy and a strong role identity were cited as important attributes. They did not consider that COT had an active part in the socialisation process but they were aware of the ways in which practicing occupational therapists could infiltrate into lay culture and take a higher profile, a point made in the following extract.

COT4: I think what the College would wish was that anyone who came in contact with that... member of OT staff... er qualified, student or support worker, would feel that they understood that they had received occupational therapy, why they had received it, what benefit they have derived from it... From the position that I sit now where there is a great demand that we produce leaflets and posters and things of that nature erm... and being very happy to do that... But the main ambassadors... for the profession are going to be those... twenty odd thousands souls who perhaps on average have contact with five other individuals, be they colleagues or patients, each day. And it's... all of those people... and that awareness of that positive view that is the most important.

All of the respondents considered that the most important instruments for socialisation were fieldwork placements and role models, a view expressed in the following quote.

COT1: I think fieldwork has... probably... because I don't know whether that element of professional socialisation... I don't think the universities or the role of the norms of what happens in undergraduate education... the university as a whole, is necessarily appropriate in that situation. You know behaving as a student is very different from behaving as a student on placement erm... and the different roles involved in those different contexts... and I think it's more about knowing what's appropriate in those different places... shifting that behaviour... to what's appropriate.

Lifetime Commitment

The respondents had mixed views on life commitment. When asked how long they expected occupational therapists to remain in the profession their answers ranged from a relatively short period of time,

COT3: I hope, in order not to waste their training, at least two years.

To,

COT4: I would hope and I believe that the... you know the average number of years is a very significant one now erm... it's certainly an average of 15 years at least.

To,

COT7: Oh all their working lives and when they retire they can do voluntary service overseas [laughter]...

In fact only two respondents expected lifetime commitment and several expressed surprise or were 'amazed' when people had remained in the profession for a long duration of time. This was partly attributed to occupational therapy still being a predominantly female profession, with an expectation that there would be career breaks for child or family care. But there was also a realisation that work culture has changed: as reported in this quote, lifetime commitment has become something of an outmoded concept.

COT2: I think there's this concept of port folio career... doing this and that and trying to do your best with the resources you've got and the limitations you've got... perhaps you expect people to move more... in and out the different arenas.

This respondent considered it to be a positive change.

COT5: I think it's also quite healthy if you can move out of it and go and do something else and go back into it... I think that people should move on they've got a number of transferable skills.

The COT representatives were not actively involved in socialisation but they considered it to be a necessary process, delivered through fieldwork and role models. They saw it in terms of producing ambassadors for the profession who would make positive inroads into lay culture. They adopted a modern approach in not expecting lifetime commitment but they were keen for people to stay in the profession long enough to ensure that the investment of time and money in educating them was not wasted. Educators are more closely linked with socialisation so what is their stance?

THE VIEWPOINT OF EDUCATORS

The educators wanted occupational therapists to portray the same attributes as those cited by the practitioners and COT representatives. They too, were conscious of occupational therapists' duty to promote the profession to the general public as well as to patients. For example,

T4: I would like...(2)... students from here... to be first and foremost... concerned with... their clients...(1)... the illness experience...(3)... And I'd [also like them] to be... obviously knowledgeable... and experts and everything... but...(2)... er... and be able to relate... what occupational therapy is about... to their clients... and members of the public

The most important aspect of fieldwork was in achieving a level of understanding that could not be easily articulated or taught didactically. One educator gave this advice to students prior to undertaking fieldwork placements.

T4: For me... the two questions which are fundamental to... OT... students... that anyone has to ask...(1)... one is asked by the... client...(1)... which is...(1)... 'How can I... the client...(2)... help you... the OT... make sense... of what... it's like for me to have...(1)... depression... or whatever...(2)...?' And the other question is... 'How can I... the OT... try and make sense of what's going on in this client's...(2)... world?'

Although fieldwork was perceived as the time when most socialisation occurred it was supported within the university setting. Giving case presentations and post fieldwork discussions were encouraged to reinforce the things that had been learned, to make sense of negative experiences and consolidate the link between theory and the realities of practice. As this educator explained, students were being prepared for a less than ideal world.

T2: We have a lot... of our seminar groups... our discussion groups... it is important to preserve...(1)... those... in particular in discussion in relation to fieldwork because sometimes students come back and say... 'This isn't how it is... people aren't able to work in a client centred way'... They would love to... pick up you know... and then... we discuss that... you know we want them to be the OT's to go out and change things... But also we don't want them going out and being totally disillusioned... and giving up altogether because... life isn't that great and you need to be prepared...(1)... erm... so it's... it's through discussion through exposure to... to fieldwork... as well as... as theory.

Lifetime Commitment

All of the educators thought that occupational therapists should have a long term if not life time commitment. They re-iterated the ideas that career breaks and changes in culture make it more likely that people will change direction eventually. This educator identified another interesting point: mature students will have shortened career duration but can nevertheless deliver a valuable contribution.

T3: I think... for investment... I mean we're talking about a lot of money... being invested in their training...(2)... I... am willing... to take students... who are... coming up to fifty...(3)... because... they have ten... years... of work... in them...(1)... and a lot of those... at that age... know they will do that... with enthusiasm... and... life experience.

Repaying the investment of time and money back to society was a common theme. This educator expected a commitment to health and social care of five years

T2: Five years... at least... because I think... you know it's... it's... if someone is working as an OT for less than that... then the profession has... has given them more than they have given... clients.

The educators were interested in giving occupational therapy a higher profile in lay culture by producing socialised practitioners who behaved in a manner that would present them in a good public light. It was revealed in the chapter on service ideal that educators try to influence students' career direction, although, from the practitioners' stance, it probably has a limited effect. Educators are aware that it is a complex and subtle process leading to the adoption of an occupational therapist's role identity. Strategies are used, aimed at reinforcing the learning gained during fieldwork. They help students to process the information and prepare them for the real world of work. They have better reason than most to expect that, having expended time and energy on their education, practitioners should repay something back by remaining in the profession for some time, notwithstanding that the duration of a career will be curtailed for mature students.

Finally, what did the Council for Professions Supplementary to Medicine (CPSM) think about socialisation?

THE VIEWPOINT OF the COUNCIL for the PROFESSIONS SUPPLEMENTARY to MEDICINE

The CPSM representatives viewed socialisation from a disassociated stance. The major concern was one of safe practice, as this respondent reported.

CPSM1: I think the only one single image... that we would be concerned to put across to the public... is that... our registrants accept the onus of responsibility for their own conduct policed by peer review.

The nuances of socialised behaviour were not something, with which they were immediately involved, according to the same respondent.

CPSM1: That's not really an issue for us... unless it goes so far over the top that... the person's behaviour imperils their competence and ability to practice.

However, they recognised the need for socialisation, placing the onus on educators, fieldwork placements and role models, as this respondent explained.

CPSM2: Some of it is learned in... the basic core... programme, educational programme...(2)...One would hope... that any individual going into... one of those professional training... educational training programmes... would have a vision, an idea... of... what they feel... that job is. And that... being a...that's what a professional is...erm. Then they learn it by...(3)... role modeling... from practitioners that they work with during their education and training... as well as the tutors at the college erm... And they learn it by talking about it... About... how the effects of their behaviour or... how their behaviour can affect other people.

Lifetime Commitment

All of the respondents realised that, whilst it might be desirable to have lifetime commitment, times have moved on. The least that should be expected, according to this respondent, is for students to put something back into society.

CPSM2: I would hope that once... immediately qualified, that people would go out and practice... the art and science of occupational therapy and sort of gain confidence for at least a couple of years.

This respondent argued that, although occupational therapists may not be permanent members of the profession there should be flexibility in allowing them to be eligible towards rejoining it.

CPSM3: There is a... flexibility... required from employers... of the profession without being overboard for allowing... women... the overwhelming majority are women, to erm... to come out of the

profession to bring up children until they go to school...those who would wish [to do that]. They ought to be able to do that without... er unduly spoiling their chances as a professional... A flexible approach to them coming back... how they come back, work part time or perhaps from a different angle... somebody has to provide top-up courses to provide returners' courses.

The CPSM representatives took an umbrella view of socialisation. Responsibility for it was placed with universities, particularly through fieldwork and role models and there was an expectation that it would continue into the workplace. They were more concerned with the end product being a safe and competent practitioner. In line with the others they did not look for lifetime commitment but did expect repayment of the time spent in education. Conscious of the need to retain staff they were concerned that employers should be creative in facilitating a return to the profession for those who had career breaks.

SUMMARY AND DISCUSSION

Practitioners, educators, and representatives from COT and CPSM were all concerned to introduce socialised occupational therapists into society, making their interactions more widespread and thus giving the profession a higher profile in lay culture. Generally, the representatives from COT and CPSM took a distant view of socialisation but they did expect occupational therapists to be embedded with normative structures. That role was placed at the door of universities, fieldwork and role models. The socialisation experiences of the practitioners, however, formed an interesting pattern. Apart from those who had previously worked in health and social care settings the practitioners had entered occupational therapy education with little prior knowledge of what it entailed. Because most entrants are now mature students, their varied life experiences could make it difficult to superimpose new values onto old. However, transformations did occur throughout first, education and then work experiences. One of the effects of socialisation was that it was seen to influence individuals' eventual choice of work setting. Yet, students did not necessarily steer towards areas of greatest need. Educators attempted to channel students into care of the elderly, mental health and so on but the practitioners still followed their own interests. There is though, potential for stimulating interest in those low status areas. A quarter of respondents' came into education with a burning ambition to work in a particular area and their career direction remained the same (there was a slight tendency towards community work). The value of searching out and nurturing this type of potential recruit is clear, especially where their interest coincides with a targeted area.

Fieldwork was considered to be a major instrument for socialisation by each of the groups. Fieldwork placements brought about many adjustments in self-perception for the practitioners. They were largely viewed in a positive light but even when people encountered a poor experience it was turned into an opportunity to learn 'what not to do'. Typically they were instilled with the idea

that learning is a lifelong endeavour. It was a time when they could try out the role of occupational therapist to see if they liked it and they began to associate with the future role. Idealism was replaced with realism and they developed opinions about different work settings. It also confirmed the reality of the world of occupational therapy and an individual was able to form a personal understanding of it. The professional skills that were learned included being able to cope with clinical responsibility, exercise clinical reasoning, communicate, both verbally and non-verbally and handle the human body in an appropriate manner.

Role models played a significant part in generating change. Their value was not so much in teaching concrete skills, although this was important but rather in passing on what had been learned through experience. It was to do with anticipating potentially difficult situations and avoiding problems in the future. High standards of work, reliability, diligence and organisational skills were traits that were most admired. There were also intangible skills that were absorbed from role models, who may not have realised that they were demonstrating them. Kindness, calmness, warmth, humour, putting patients at ease, being approachable and a good listener, being able to interact on a number of levels with all sorts of people, were all highlighted. Individuals who possessed all or most of these qualities were noted as having a strong role identity. They were believable and trustworthy role models because they were perceived to be playing the role well. Using the looking glass analogy the practitioners, whilst students, had marked these qualities as meaningful, they imagined that others would judge *them* well if *they* had the same traits and they associated that with pride and esteem. Such was the meaning of these attributes that people were prepared to endure hard times in order to absorb them. These concepts were highly valued by educators but realising that they were not amenable to didactic teaching, they nevertheless helped to consolidate these mores, once students were back in the academic institute. This tacit knowledge is such an important part of professional action that the ways in which it can be integrated into university curricula are worthy of exploration.

The transition from student to occupational therapist happened gradually. There were several turning points that assisted the transformation in self-perception. The award of the degree, securing the first job and then moving to higher positions with specific titles marked movement up the career ladder. Other turning points were more abstract, yet they formed a pattern. Physical objects such as a uniform or tools of the trade were symbolic of an acquired position. The way in which others behaved towards an individual was significant. It would take time for a newly qualified occupational therapist to be accepted as such by colleagues. When someone was first treated as his or her title dictated it was considered eventful. Withdrawal of supervision indicated that the individual could be trusted to perform in the manner expected. Interacting with others who had less knowledge marked the fact that progress had been made. Sometimes it was only when people looked back that they could see that a change had

occurred; teaching something to a student would often cause people to recall a time when they were unable to address patients' questions, for example. Being able to convert something complex into lay terminology was another indicator. Crises such as a patient making a complaint, falling, having a heart attack, threatening suicide, demonstrating challenging behaviour or some similar incident are transforming occasions. Whilst their precise nature will be unique to an individual, these are situations that have happened to all occupational therapists and form a rite of passage that initiates people into the profession.

Socialisation transformed these practitioners in all sorts of areas. Lifetime commitment, however, is an exception. Most practitioners, even those who were fulfilled in their post would be prepared to leave the profession at some point. Partly, this is due to a culture shift, which has raised an expectation that a career will be composed of several job changes. There was an acceptance that this was the case by the educators and representatives from COT and CPSM. All groups wanted practitioners to remain in the profession at least long enough to contribute something back into society. Given that role transition continues long after qualification it makes the point more moot. One of the consequences of having mature entrants to occupational therapy is that their career duration is already shortened. But the other factor that would drive occupational therapists out of the profession is that, having gone through this socialisation process, they find that they are unable to practice in the manner that they have been led to believe is correct because of bureaucratic constraints. The current agenda for increasing the throughput of patients, for example, has led to many occupational therapists finding it difficult to fulfil the service ideal. This is a matter of concern for those who are charged with the task of improving recruitment and retention of practitioners. The service ideal assumes that professionals will always act in the best interests of patients, put self-interest aside and provide the highest standard of service. Having socialised occupational therapists to do that, it behoves those responsible for the organisation of the profession to enable them to do so.

CHAPTER 10

CRITIQUE OF STUDY

This chapter gives a brief overview of the techniques used in the study and their level of success.

The study has facilitated an understanding of how the meaning of professionalism has changed as a result of the way that people; in this case, practicing occupational therapists, educators, members of organisational and statutory bodies interact with one another. The intention was to generate understanding rather than to produce a theory. The task was to make into an explicit and comprehensive form something that was known incompletely by the participants. An interpretive synthesis was undertaken using narrative summary. A systematic technique for identifying categories was employed. The text was used as indication of an underlying pattern. It was a way of discovering and conceptualising the ways in which people made sense of themselves and their worlds. One of the criticisms of this type of analysis is that it may lack transparency but I have provided the frequency with which a cluster occurred, given the minority as well as the majority viewpoints and presented information about the initial codes and themes in the Appendices. This trail of evidence is made available for the reader to verify the conclusions made. Grounding the findings in the data, using verbatim quotes and paying attention to linguistic form, addressing bias and revisiting the literature has enhanced the confirmability of the study.

The Sample Group

The sample group of practitioners worked out well, with an even spread of those working in community, mental and physical health and across grades of staff. The data collected from each of the groups was adequate for the analysis. There were no differences in opinion that could meaningfully be attributed to variation in characteristics of the sample. Any discrepancies were quite minor. For example, no physical occupational therapists reported using a framework model to inform their work and some of those in mental health claimed not to use concrete theory but essentially this knowledge did not change the overall picture. There was remarkable thematic congruence between the diplomates and graduates. There was a tendency for more graduates to use abstract theory but not sufficiently great to be significant. The opinions of both groups as a whole were consistent with one another. I had expected there to be more divergence. The fact that this was not the case adds more veracity to the results. It was still useful to construct the sample in the way that it was, however. Knowing that it was junior staff who were most likely to use abstract theory, to be confused about state registration, to lack experience in ethical judgments; to be aware that some graduates felt that they had been poorly prepared for the job and that some diplomates thought that their qualification had lost kudos, added greater depth and piquancy to the data.

It would have been helpful to interview more educators because saturation point was not achieved and possibly there are issues that have gone unexplored but I also needed to ensure an adequate range of respondents from each university. However, because of the voluntary nature of the sample, I had to settle for only four in total, whose duration of experience ranged from one to over thirty years. Respondents included both genders and their teaching duties encompassed aspects of community, physical health and mental health care. It has to be accepted that this data may be incomplete. A wider range of viewpoints on issues such as whether or not occupational therapy has a unique skill, the ways in which business activity impinges on effective control into professional education, the ways in which existing theory does or does not inform practice, might have provided greater richness to the data. Nevertheless, for the other groups, sufficient data was collected to reach saturation within the analysis; the point where no new insights were gained (Sim & Wright 2000).

There may have been some analytical value to be gained from interviewing the practitioners prior to the representatives from COT rather than the other way round. This would have allowed me to probe the professional body more about issues that were raised by and seen as relevant to, their practitioner members. Issues here may have included looking at how the gulf between the professional body and practitioners might be addressed, how the COT would reply to those who described the skill as 'common sense' or who decides what the guiding paradigm should be. On the other hand, I judged that I had become a much better interviewer after the seventh conducted and this could simply reflect my personal growth in having a better understanding of the process.

I started with the premise that the meaning of professionalism would alter as individuals made interpretations about its various aspects. Differences in interpretation between groups were teased out. The collective view was compared to that of individuals within organisations. The process of defining professionalism; the actions that have been refined, changed, transformed or abandoned, have been explored. Actions are guided by taking into account what others do. Events were imposed on the College of Occupational Therapists (COT), educators and the Council for the Professions Supplementary to Medicine (CPSM). For example, a culture change has occurred in wider society that has generated the notion that a degree is a preferable credential to a diploma. Symbolic interactionism has facilitated an examination of what happened, within occupational therapy, in the light of this event. As Blumer (1969) advised, such events have been seen, analysed and explained in terms of the process of interpretation engaged in by the participants as they handled the situation from their position in the organisation.

Insider/Outsider Issues

There is an increasing acknowledgement in qualitative research that the researcher cannot be eliminated as an influence on data generation. There is an

interaction between interviewer and interviewee within which both create narrative versions of the social world and the subjectivity from the researcher should be made overt (Patton 1990; Silverman 2004). I should therefore state that I have worked as a practitioner occupational therapist for most of my career of 28 years and also now have experience as an educator. As such I had experiential knowledge, which enabled me to have some understanding of the practitioners' and educators' world. When participants spoke of the erosion of practical skills, of the speed of patient throughput, of the tedious and enjoyable aspects of the work, or of the difficulty of failing students, I have known similar issues. Whilst acknowledging that individual experiences are unique to the participant, nevertheless I felt that I shared some of their frustrations. My own professional qualification is a diploma, not a degree. One of my motivations for undertaking this study was a desire to find out why the change from 'training' towards a diploma to 'education' towards a degree was considered necessary by the COT. Anecdotal evidence from colleagues suggested that there was an expectation that graduate occupational therapists would make better practitioners than diplomates because they would be more analytical about their interventions. However, the same colleagues considered that this expectation had not been met. Taking an insider, or emic perspective according to Patton (1990), allowed me to draw on some shared understanding of the world that participants were describing and to know something of what the experience might feel like.

However, such a stance would also carry the risk that I might be selective in my analysis and interpretations. In order to combat this, I used a number of strategies. I composed and presented the interview schedule in a way that did not reveal my own opinions. As the data were analysed and cross-referenced with each of the groups I tried to adopt an expectation of 'seeing what was there' in order to present a balanced argument. I was keen to take an even-handed stance in presenting the views of both diplomates and graduates. It is inevitably the case that some participants would be more articulate than others. When presenting illustrative quotes I took care not to give undue bias to those who expressed themselves more clearly and have tried to demonstrate the viewpoints of all concerned. Wherever possible I put quotes in place from mental health, community and physical health subjects. One of the reasons for collating types of quote was to demonstrate transparency about the relationship between a particular point presented and the wider pool of responses from which it was selected.

Similarly, I sought to include negative cases and minority viewpoints to reveal the multiple dimensions of the topic. There must always be some data selection in constructing analysis but in presenting the analysis as I did, by leading the reader through the route by which I reached an interpretation, I attempted to make clear why I came to that conclusion. I was aware that I held assumptions but tried not to allow them to dominate unduly or to impose them inauthentically on the interpretations. As Patton (1990) reports, empathy with the participants can be a valuable asset to the research. I knew, for example, that practitioners would have strong viewpoints about using models of practice and that it would be important

to capture their opinion and others to weigh all sides up. Using the measures described has helped to ensure that an authentic representation of this particular empirical world has been presented.

I was not taking an insider perspective throughout the entirety of the data generation. In some ways I was an 'outsider': none of the subjects were known personally to me, some of them were working in fields outside my sphere of clinical experience, and I had no experience of working for either the COT or CPSM. According to Silverman (2004), this may have analytical implications in terms of the 'wholeness' of the story that, particularly, the subjects from COT or CPSM, were trying to tell. I was a professional member but was outside of their particular worlds. Nevertheless, that does not discount the idea that it is possible to understand the meanings that people attributed to issues of professional identity through in-depth interviews. In symbolic interactionist terms, professional identity can be regarded as an object, which can be described and therefore examined. The aim remained to represent the subjects' views fairly and to interpret their associated meanings authentically. Although I was at times in an outsider position it was still possible to achieve some understanding of this objectified world.

The Analysis

The advantages of narrative analysis lie within its flexibility, allowing the researcher to be reflexive and critical. It can encourage clear and original ways of seeing things. Among other things it produced an explanation of the intent behind certain actions: participants may not have been overtly aware of such intentions but they could be seen. Self-serving actions intended to create status were evident. For example, the most popular areas of work identified were those linked to a scientific paradigm, which was contrary to the view, also expressed by some respondents, that such an orientation was detrimental to the art dimension of occupational therapy. It reflects the dilemma created by striving for personal reward whilst also attempting to live a service ideal. The code of ethics, with its symbolic intention of conveying trustworthiness, was revealed to be a more meaningful structure than previously thought by COT members, even though the document itself went largely unread. There were many indications that participants were trying to give honest opinions and trying not to be over affected by the interviewer; for example, they were prepared to divulge some areas of work that they found tedious or unattractive and the COT members particularly seemed to be willing to acknowledge weaknesses such as not being sufficiently robust in challenging government policy and having a distant relationship with the membership.

The analysis allowed me to look at 'taken for granted' concepts in a fresh light, facilitating new ways of thinking about certain issues. The ways in which the actions of occupational therapists have contributed to the perpetuation of stigmatisation in society is an example. Similarly, it has been suggested that when

professionals control the content of training there is a danger that it teaches an idealised version of the work but the study findings indicated that similar idealisation in curricula occurs when academics have control. Practitioners attributed a greater depth of meaning, in terms of its value, to the code of ethics than had been assumed by COT members. The analysis allowed an examination of the meaning attributed to concepts such as ethics, within particular circumstances, situations or contexts, thus giving a much greater depth of information than could be gleaned by conducting a survey and asking for a 'yes/no' response. This was a more effective way of explaining behaviour than looking solely for attitudes and provided the opportunity to challenge assumptions.

The symbol of professionalism was found to have meaning for these participants in the sense that it objectified what a professional is and provided a focus for the further advancement of occupational therapy but interpretation is on going. The functionalists, trait theorists and power theorists have informed the perceptions that exist today but there have been changes. It is still important for occupational therapists to have a monopoly of knowledge but it need not be linked to science. Greater transparency in the justification for what occupational therapists do is preferred to mystification. Lifetime commitment to the profession is no longer expected by members. Competence in a skill with a sound knowledge base, trustworthiness, the intrinsic value of work and the service ethic have been key throughout history and remain so. Traditionally, professional associations have a pivotal role in the organisation of such concepts but since greater state regulation they have tended to become more protectionist, which has reduced their capacity to be central in these areas. While these results may reflect the current situation regarding the professional orientation of occupational therapists there is an understanding that as the people who make up the groups changes, further interpretations will be made by practitioners, educators, organisers and regulators, partly based on previous action. There is no final end state and the professionalisation process will continue. Nevertheless symbolic interaction has proved an effective way to extract the meanings of professionalism shared by the groups in this study and an understanding of the professional identity of occupational therapists at this point in time.

CHAPTER 11

IMPLICATIONS FOR THE DEBATE ABOUT PROFESSIONALISM IN OCCUPATIONAL THERAPY AND THE DIRECTION OF FUTURE POLICY IN RELATION TO PROFESSIONAL IDENTITY

This study has followed the progression of occupational therapists' professional identity to date. It has shown the importance of consensus for progression in professional status and highlighted a lack of cohesion between the stakeholders in regard to the skill being claimed, the education and regulation of occupational therapists. There is a profound difference between the ways that practitioners and the organising bodies perceive the work of occupational therapists, which has a number of implications.

Implications for a Practice Epistemology

COT has been seen to be attempting to create a social identity for occupational therapists based on a premise that is not seen to be also widely upheld by practitioners. It is one based on an asserted conceptual dominance of science and academia whereas; many practitioners would prefer their identity to be more clearly the product of the performance of their craft (see, for example, the chapters on monopoly of knowledge, service ideal and socialisation). This poses a personal reflexive paradox for me. This study has been a pursuit of academia and the knowledge generated from it has been made more valid by drawing on scientific and academic traditions. It is therefore important to recognise that these traditions are necessary to understand occupational therapy issues and to test my own and others' ideas. They can inform the conceptual frameworks of practice but should not, however, be allowed to wholly subvert the artistic dimensions of occupational therapists' work regarded as essential by the subjects in this study.

The results of the study have demonstrated good reasons why the debate about professional identity is seemingly endless. There is currently no consensus about the desired basis of identity construction. Although practitioners and members of COT might be looking at the same world of occupational therapy they see things differently and make different interpretations from what they see. There is little common agreement on important issues such as:

- The domains of the skill being claimed.
- The guiding theories.
- The most appropriate research methods to provide evidence on practice efficacy.
- The propositional knowledge necessary for the education of occupational therapists.

There seems to be some dilemma about developing an overarching paradigm, that is, the accepted model or pattern which guides professional practice. People such as Kielhofner (1985) were instrumental in creating and promoting a new scientific paradigm for occupational therapists. However, some writers have argued that the abandonment of a paradigm based on the association between activity and health in favour of one based on scientific endeavour has led to a crisis in professional identity (Perrin 2001; Ikiugu & Rosso 2003). The practitioners in this study highlighted the need for a balance between the art and scientific dimensions of the profession. The perception was that this has not been mastered within the present paradigm. A scientific orientation has led to a distancing of the profession from its original *raison d'être*, that is, the use of activity for therapeutic purpose. In its place occupational therapists now refer to the occupations in which people are engaged (Creek 2003), whilst much effort has been put into emphasising the alignment of occupational therapy intervention with science (Wilcock 2002).

Adopting a scientific paradigm has contradictory implications for practice epistemology because it influences what may be regarded as valuable. From the outset in the early twentieth century, occupational therapists used the patronage of doctors for the specific purpose of professional enhancement. They therefore adopted the medical model, in which scientific neutrality is paramount and used it, as did other groups of health workers, as the justification for drawing on and undertaking medically-based practice, education and research (Roberts 1994). In contrast, the practitioners in this study reported tensions between what they would like their work to be (practically based intervention) and what they had been steered towards (often working as discharge therapists, continually assessing people but not treating them) where a reason for adopting such tasks was that they had greater credibility within a scientific culture. The chapter on monopoly of knowledge has discussed ways in which practitioners regard the skill base of occupational therapy as straightforward but nevertheless valuable to society and that attempts to make it appear more complex are inappropriate and possibly obstructive to job performance. Many practitioners consider the skill of occupational therapists to be more artful than scientific, but that this may be currently underplayed by the organisation. Such contradictions carry the risk of damaging individual and public impressions of occupational therapy as a valued profession. It also reduces the likelihood of practitioners making a long term commitment to the profession, as highlighted in Chapter 9 on socialisation. Although the practitioners in this study were keen to gain intrinsic value from their work, the continuing debate about the fit of the present professional paradigm has also had a negative impact on their perceptions of the merit of what they do. Such disagreements on the value of what they do may be seen as detrimental to professional cohesion and therefore their ability to act together in the interests of their professional values and practice. On the other hand, practitioners also value the status that scientific orientation attracts and this has a more obvious influence. It seems that the occupational therapists in this study are not sure whether to support or resist the scientific paradigm: whether to value

what they do and strive for it to be more widely acknowledged or to give greater emphasis to the status that may be available to them if their activities are geared towards a more scientific focus.

When groups are engaged in frequent and deep discussions about fundamental issues, the conditions are set for what Kuhn refers to as a paradigm shift (Kuhn 1970). For positive professional progress to occur there must be a change in viewpoint so that all groups are looking at problems in the same way. Kuhn (1970) argues that there will always be groups who are resistant to change and it is necessary to examine such resistance for any substance, in order to eliminate the possibility of it being the product of an interest-based entrenched position. It is also important to look at any new paradigm from a critical stance to assess whether or not it has validity for, in this case, framing the work of occupational therapists. At least two ways forward may be considered. The existing paradigm should firstly be explored more fully, with the aim of articulating theory development and examining whether or not it can be assimilated to solve practice problems relevant to the profession. If these attempts fail then a paradigm shift is necessary, requiring quite new theory, methods and standards of practice (Kuhn 1970).

Since it is the study of paradigms that mainly prepares students for membership in the professional community with which they will later practice (Kuhn 1970) this conceptual insecurity must also have implications on occupational therapy education.

Implications for Education

The results of this study have demonstrated that there is a divergence of opinions regarding the knowledge that is necessary to become an occupational therapist. The chapter on control of training into professional practice has shown that the shift to university-based education has led to a perceived loss of professional control of the curriculum content. The greater emphasis on academic enterprise produces occupational therapists who can engage in intellectual process but who are seen by some other practitioners as less well prepared for the practice setting. The inference was that the development of technical skills is given a secondary importance by the university hierarchies, yet practitioners considered this to be the most important aspect of what they need to know. They stressed the invaluable part that fieldwork placement played in their education overall. This is consistent with others who have expressed their views in increasing calls for the education of professionals to encourage much greater integration between university and practice environments (Hunt et al 1998; Richardson 1999a and 1999b; Higgs et al 2004).

Constructing a unifying paradigm is the first step towards identifying what propositional knowledge needs to be taught. A scientific paradigm drives the movement towards a focus on abstract processes that carry an aura of scientific

credibility; an alternative one might lean towards a conceptual emphasis on skilled craftsmanship. A fit between paradigm and propositional knowledge, is necessary so that progress can be made towards developing and refining the skill base. Higgs et al (2004) caution that rather than regurgitating the same knowledge in perpetuity, practitioners and educators have a duty to facilitate a particular flexible and integrative way of thinking in their students. Students need to build on propositional knowledge and synthesise it with their unique fieldwork experience. Educators, both clinical and academic, should share examples, for assimilation, from their own professional experience. The appropriate propositional knowledge could then be integrated by students, along with experiential knowledge about how facts can be interpreted and how problems are solved in work situations. This collation of knowledge creates thinking patterns that encourage students to take a critical look at the credibility of what they do and in this way professional knowledge is advanced and can be gathered to formulate a professional paradigm (Higgs et al 2004). It also has the effect of making it clear how competence is understood and recognised, the importance of which has been raised throughout this thesis. Knowledge generation then would be practice driven, something that many of the subjects in this study have advocated, particularly within the chapter on control of training into professional practice.

One of the ways that this can be achieved, Richardson (1999a; 1999b) suggests, is through an educational process, which draws on the principles of symbolic interaction and situated learning. For example, videos, tape recordings and transcripts of real practice situations can help students absorb implicit knowledge about professional action. Not only would they absorb information about clinical reasoning and all the nuances involved but also about those occasions that make up real practice, when the application of objective factual knowledge will not resolve a problem. For example, students could examine situations where a patient is demonstrating challenging behaviour. They could observe and analyse the ways in which experienced occupational therapists manage this problem and learn to apply those skills. Similarly they could develop an understanding of the aspects of intervention that are considered most meaningful to the clientele, which would help to guide professional knowledge so that it serves patients' needs and also enhances professional status in regard to being responsive and trustworthy practitioners.

The discussion in Chapter 5 on control of training into professional practice indicates that indecisiveness about a suitable paradigm may lead to erratic theory and knowledge development. These practitioners did not make appropriate use of theory. This was interpreted as reflecting their judgement that they do not consider those available to be applicable to their work. The implication is that their work would benefit from closer examination to reveal a better understanding on which to build theoretical knowledge. Adopting a single paradigm and reaching agreement about propositional knowledge, could help streamline theory development. When all parties look at the world of occupational therapy in

similar ways they may be more likely to view research engagement in more integrated ways. There may be a shift in the criteria determining the legitimacy both of problems and proposed solutions (Kuhn 1970). The assumption within the medical model is that objective (quantitative) research methods have particular legitimacy, whereas other models may advocate more subjective methods. There were many occasions in this study when subjects reported their frustration that current research did not lend itself to revealing the 'real benefits' of occupational therapy intervention (monopoly of knowledge chapter). They had a perception that quantitative research was given more credence yet they wanted the more multi-faceted psychological, social and other benefits of occupational therapy techniques to be illuminated, not just the biological. Such problems may lend themselves more to qualitative rather than objective methods of exploration. Whilst this type of research has now become more established it still attracts criticism (Flick et al 2004): a preconception which can be challenged for professions with a strong care element.

Kuhn (1970) recognised that there was much semantic debate about what constitutes a science and argued that the efforts of some occupations to align with the term were sometimes fruitless. It simply reflects a desire to match the success of occupations associated with natural sciences (physics for example). However, he contends that when an occupation achieves consensus about past and present accomplishments; when agreement is reached about what the work is about; this is all that is required for the desired status to result. This could have relevance for occupational therapy. Unity is of prime importance as the absence of competing schools of thought may make progress in professional status far easier, especially where there is a powerful explanatory framework appropriate to the field of investigation (Kuhn 1970). Yet, an investigation of the developing paradigms of physiotherapy of a cohort of students in two schools of physiotherapy showed that there was no purposeful effort to influence their developing paradigms. Students had little idea of the mode of practice or of the unique part played by physiotherapy in health care (Richardson 1999a). The same ad hoc approach to paradigm acquisition could be inferred for occupational therapy students. Agreement about an overarching paradigm, relevant to an identified skill base, is a necessary starting point and has benefits, potentially greater than creating a scientific alignment, in terms of developing an understanding of the composition of occupational therapy and assimilating this knowledge into practice and education.

Implications for the College of Occupational Therapists

The professional body for occupational therapists (College of Occupational Therapists) has become focused on protective functions; gaining protection of title, resisting excessive government control of professional standards, status building through an emphasis on high academic requirements and links with science. That is part of their role. But if unification is the key to professional identity, recognising and addressing this could place COT in a prime position to

manage future action, including policy-making aimed at steering the direction of the profession. This study has identified the weaknesses in the professional project for occupational therapy. The necessity to decide the most appropriate paradigm is most pressing for educators and practitioners. The importance to cohesion, of making a solid commitment to a unique skill has been highlighted in the chapter on monopoly of knowledge. Advocating strong professional control about what the work of an occupational therapist should be and setting clear boundaries is also most important, as discussed in the chapter on control of training. Entrance to the profession must be controlled to maintain consistency in the competence of the emergent occupational therapists. Once there is a more uniform recognition of the constituents of competence, regulation of the profession can be undertaken more effectively. This, in turn, can influence the components of the code of ethics and the ways in which a service ideal may be implemented. This study has set out for the first time the current position of occupational therapists' professional identity. However, to build on these insights and for the profession more broadly, to decide where it wants to be in the future a strategic plan is needed. This could be usefully coordinated by COT, in setting out the ways in which such issues should be addressed and enabling a clear, unified focus for future development.

Implications for Professional Identity

Placing the emphasis on strong professional identity, seen in these concluding chapters, may seem antithetical to the modern trend for inter-professional and inter-disciplinary working but the issue is complex. This research has resonance with that of Richardson (1999a; 1999b) who examined socialisation for physiotherapists and concluded that the process needs a strong and internalised view of what it means to be a physiotherapist. Her argument was that practice, which is geared towards multi-disciplinary and inter-disciplinary teamwork, has benefits for client-centred care but reduces professional autonomy but that the challenge is to retain and value the unique skills of the professions within this collaborative framework. Professional members need to understand who they are, what they do, how they do it and why they do it if they are to be confident in resisting negative influences of workplace culture, such the undermining of self-determination. Within this study, the chapter on the service ideal illuminated the ways in which practitioners considered one of the attractions of professional identity to be the high esteem gained through belonging to a group that had a valued expertise with connotations of moral purposefulness. When people are motivated in this way and they have a strong sense of who they are, they are better equipped to abide by the rules of a service ideal. They are then more likely to perform their work in the patients' best interests, which may sometimes lead them to act as advocates and to resist policy that is perceived to have a detrimental affect on care. Thus, it is prudent to retain the concept of professional identity and thence to develop ways of integrating this with inter-professional and inter-disciplinary working.

This study has shown that there is an identifiable process through which socialisation of occupational therapists takes place, culminating in the internalisation of core elements of professional identity. It is an individually experienced, dynamic process, which continues from studentship onwards. It is formulated as people encounter experiences along the way: self-conception is transformed through reflection on their before and after selves in the light of these events. Within the socialisation chapter, the examination of turning points that occupational therapists encounter whilst accepting professional identity, demonstrates how vulnerable the newly qualified are in the early stages of their experience. A clear understanding of what, how and why occupational therapists perform their work and an education that teaches this, whilst blending propositional knowledge with the multi-dimensional facets of real practice situations, has benefits in terms of helping new practitioners to negotiate the process of internalising professional identity. Understanding the nature of the turning points in this process provides knowledge about the ways in which they may be managed, using the experiences of academic and fieldwork educators.

The adoption of an agreed paradigm is crucial to establishing the basis on which to build a professional identity for occupational therapists. It can illuminate the nature of the skill and the ways in which it is unique to the profession. An understanding of working cultures can indicate where the skill should be practiced to be most effective. It can guide the methods used to research the skill and advance professional craft knowledge. Theory can be rooted in practice, increasing its relevance to practitioners and making it more likely that their work will be evidence based. Because the skill is made overt, the components of competence can be revealed, clarifying the standards to which practitioners may be expected to conform. This can create opportunities for some to achieve an acknowledged reputation and to strive towards an identified pinnacle of excellence. Once competence is understood, deviations from it can be more positively addressed, providing the opportunity for the profession to become more disciplined. When methods of policing become clearer, self-regulation becomes more trustworthy. An appropriate match between paradigm and practice has the potential for the work to be viewed as valuable by society. It can provide an avenue through which philosophical ideals can be expressed; the moral and ethical dimensions that are considered important, as discussed in the service ideal chapter. This could give the profession a greater authority, which can be utilised for the benefit of society in patient advocacy. Structuring the profession in this way facilitates a shared understanding of the composition of the knowledge base, how the work should be performed and the meaning attributed to practice.

In essence, this knowledge about 'what, how and why' occupational therapists' work is performed is an interactionist conceptualisation of 'who' these people think they are. In Goffman's (1967) terms, in discussing identity this represents a construct which has been organised in a particular way with inbuilt rules of engagement. Such rules, when followed can strongly shape an individual's evaluation of him or herself and colleagues, the result being a more robust

professional identity associated with a highly regarded sense of self. Such a construct can confer specific benefits to the individual (a socialised self imbued with pride), for the profession of occupational therapy (retaining a defined place in the market) and for society (serving a valued and specific need).

Outline of Ideas for Future Studies

In brief, the three main areas for future studies that could suitably follow on from this one are:

1. An examination of the components of occupational therapy practice – what do they ‘do’?
2. An examination of the components of ethical practice.
3. An examination of whether or not the work of occupational therapists can be aligned to an existing paradigm.
4. If the existing paradigm is found to be inappropriate, a new model, specific to occupational therapy should be generated.

Examining the Components of Occupational Therapy Practice

The analysis of the findings has indicated that occupational therapists are unclear about the nature of the skill being claimed as the foundation of the profession. There is a dichotomy of opinion between practitioners who give meaning to the art dimensions of the skill and COT members who strive towards a more scientific orientation. The data generated from this research is based on what occupational therapists say they do. It provides a starting point, outlining their perceptions. This is what the study set out to do. But whether and how this harmonises with what they do in reality is not yet known. The next logical step would be to observe occupational therapists at work to find out what they actually do. It would be beneficial for the purpose of developing a deeper understanding of the skill to discover what aspects of a professional interchange are considered meaningful to occupational therapists, how they define what needs to be addressed, what constrictions they encounter, how they decide which intervention would be appropriate and the determinants on which they base their decisions. It would be helpful to gain an understanding of which aspects of occupational therapy practice are perceived to be beneficial by patients and others in health care teams. In this way the components of occupational therapists’ work can be fashioned into a construct and examined to highlight whether or not it is possible to decide that the skill has an artistic or scientific base.

Examining the Components of Ethical Practice

Much has been made, in the findings, of the importance of competence and ethical practice but it is not yet clear to what extent occupational therapists share perspectives about definitions of these concepts. Once the nature of the skill has been made more transparent, efficiency in the way it is performed may be more readily identified and assessed. Similarly, the practitioners in this study have presented themselves as ethically orientated. It would be prudent to find out the extent to which such ethical orientation is reflected in their day to day performance. In what ways is their behaviour regulated? What interactive

processes are at work? At what point is behaviour construed as unethical? Speech and language therapists have completed a thorough documentation of the standards of behaviour expected of their practitioners in different service locations for a range of client groups and presenting disorders (Royal College of Speech and Language Therapists 1996). This was compiled after a detailed analysis of what a speech and language therapist does in practice and may be a useful point of reference for other professions. It is the actions, interactions, behaviours and the way people interpret them that are key. To determine these, a range of dimensions need to be investigated including the daily routines, conversations, language, and body language used (Mason 2004). It would be pertinent to investigate when and under what circumstances examples of ethical behaviour are employed. A better understanding of competence in occupational therapy would inform the standards of behaviour required, which would in turn facilitate an examination of the components of ethical practice and inform the code of ethics.

Capturing this type of information will produce different data to that derived from the interviews and is likely to reveal more contextualised evidence for the nature of experience in that situation at a particular point in time rather than relying on people reliving their experiences. The resultant data from 'natural settings' could be used to build on that already gleaned from interviews, to develop a deeper explanation of the work of occupational therapists through a more developed interpretative analysis (Mason 2004). Symbolic interaction has proved to be a successful framework to facilitate this type of research. Taking this epistemological stance would suggest using observational methods of inquiry, to enter a setting and observe, participate, interrogate, listen and communicate with the interested parties (Mason 2004). Higgs et al (2004) advocate this type of research to elicit what they called professional craft knowledge. Through complementary methods such as observing practitioners' critical conversations with peers the clinical, ethical and moral reasoning components of knowledge can be identified. These techniques can help to identify what informs practitioners' problem solving; how they know that a particular intervention will work for that patient, in those circumstances, within that organisational context. In addition it can expose methods through which they come to know that something will not work and how occupational therapy intervention is integrated with that from other health care workers.

Examining the Work of Occupational Therapists against an Existing Paradigm

Understanding the work of occupational therapists means that the relationship of what they do to existing theory can be examined more fully. The practitioners in this study have revealed that they do not appropriately use the theory currently being taught during their education and that there is some tension about whether or not a scientific paradigm is an appropriate practice guide. However, the study was limited to what people said they were doing. It is possible that occupational therapists are using theory without being able to articulate it clearly. Revealing

their practice and making critical comparisons will shed light as to whether there is a 'fit' between any theory they do use and the existing scientific paradigm.

Some of the theory available to occupational therapists has been generated from the medical model of practice, widely used within the profession. The product of the medical model is widely seen as being a reductionist type of rehabilitation where occupational therapists concentrate on the impairment and a limited dimension of disability (College of Occupational Therapists 2002b). An alternative, the social model, looks toward changing the physical and psychological fabric of society so that people are integrated into society rather than being treated as having special needs (Roberts 1994). However, there is an acknowledgement that healthcare workers are restricted in their ability to consider the wider dimensions of social handicap and can become part of the problem by perpetuating the concept of disability (Roberts 1994; College of Occupational Therapists 2002b).

The biopsychosocial model has received particular recent attention; a model on which the International Classification of Functioning, Disability and Health (ICF-2) has been based (World Health Organisation 2001). It conceptualises people as being composed of three inter-related components; biological, psychological and social (Engel 1977). Therefore they function at the body, personal and social levels within their individual, personal and environmental contexts (College of Occupational Therapists 2002b). Because occupational therapy is concerned with individuals' activity limitation and participation relating to personal experience and aspirations, the biopsychosocial model has been put forward as a central framework to inform health and social care practice but a clear decision has yet to be given by COT (College of Occupational Therapists 2002b).

Generating a New Model to Guide Occupational Therapy Practice

Careful scrutiny of what occupational therapists do, as indicated in this present research and suggested here for future research, examining the components of their knowledge, will facilitate comparison against these existing theories and associated framework models, for compatibility. This would allow investigation into whether or not the existing paradigm guides practice and give some indication of which model, if any would be most suitable. If it is the case that the present paradigm is not serving its purpose, a model unique to the profession may be developed in a paradigm shift but for this to happen all of the groups involved would need to be converted to the need for such a re-direction. This would require practitioners, educators, members of the organisation and researchers to collaborate in a critical appraisal of what occupational therapists do and why they do it. They would need to agree on the value of developing a synthesis of experiential and propositional knowledge, which could be used to formulate a new paradigm, which could more satisfactorily explain, guide and offer solutions for the problems encountered by the profession.

CHAPTER 12

CONCLUSIONS

This study has produced empirical evidence, rooted in the data, which has generated an understanding of the factors that influence professional identity and status. It is the first study of its kind to answer a key question, which other professions have faced, about the future of occupational therapy. Synthesis of the data has allowed Becker's symbol of professionalism to be inspected from the perspectives of practitioner occupational therapists, educators and representatives from the College of Occupational Therapists (COT) and the Council for Professions Supplementary to Medicine (CPSM). The results show that the professional symbol as a conceptual framework remains relevant for modern health professions albeit with the modifications that will be discussed in the following paragraphs. The findings pertain to this theory, for these groups at this point in time and offer a benchmark to demonstrate the position of occupational therapy along the continuum toward the end state of 'profession'. These new data have revealed the collective actions that are most likely to facilitate an improved professional identity for occupational therapists.

In brief, professional identity stems from unity. A profession must act as a homogenous unit, the net result being individual and collective esteem and status. The components for a strong professional identity are:

- Identification of a unique skill
- Orientation to a theoretical paradigm that is consistent with the nature of the skill
- Research methods that can discern the value of the skill
- A high public profile through which the profession can act as an advocate for its clientele
- An emphasis on a moral dimension, accommodating intuitive caring and empathy
- Professional control of what form the work should take
- Effective gate keeping, to guard against inappropriate admissions to the profession
- Competence
- Effective monitoring of competence
- Effective discipline
- A strong code of ethics
- A guarantee of trustworthiness

Although many of these features are influenced by 'modern' values of professionalism based on expert knowledge they are bounded within the 'traditional' values of status. There must be the opportunity to achieve a reputation (and an esteemed social identity) by doing well in an area of interest.

The opinion of Talcott Parsons, expressed in 1939, that professionals were just as interested in achievement and recognition as business people, still has resonance for this cohort. This list of attributes bears a close resemblance to those produced by the much aligned trait theorists. It demonstrates the degree to which such traits have become embedded in generalised knowledge. The difference, for these occupational therapists, is that the theoretical base does not need to be scientific as long as the skill is for the public good. This list is a useful way of illuminating the path towards professional status. It represents what the profession wants to be but it is not enough on its own. It needs to be viewed in the context of differences in interpretation about the most appropriate action, what actions have occurred, what the outcome was, the shifts of direction, what else has been influential and what should be done in the future. The ways in which interacting groups in the real world experienced these constructs are summarised in the next paragraphs.

Monopoly of Knowledge

Essentially there were differences in interpretation between the groups. CPSM considered that to claim a unique skill was a prerequisite of professional status. Practitioners agreed and thought that occupational therapy fulfilled this criterion. However COT and educators were less convinced. The difficulties stemmed from the rejection of craftwork and the failure to replace it with a discrete area of work that could convincingly be orientated with science. Practitioners were torn because they understood the relationship between science and credibility but there has to be a balance. They interpreted much of what had been done, in the interests of advancement, as pseudo-science and provided evidence of mystification, which was masking the fact that the skill of occupational therapists was straightforward. Notwithstanding the simplicity it has considerable value to society which is not being adequately highlighted. In their opinion, too much science is counter-productive: it leads to inappropriate research methods that conceal the true worth of the skill, it generates theory that is incompatible with the work place and it creates unrealistic expectations of the job. Nevertheless practitioners were interested in gaining status and engaged in impression management to evoke deference from patients. Work was important for their social identity and enhanced esteem. Professionalism has the potential to provide it but it must be delivered through a highly regarded, practical skill, not a manufactured expertise.

The collective action of COT and educators was to move closer towards science but individuals within these sectors were making their own interpretations, which revealed tensions and anxieties about that decision. They agreed that science could undermine the value of the skill, that theory needed careful scrutiny and the research base needed to be more relevant. One of the aims of linking the profession to science was to gain status but whether or not this been achieved is questionable. Occupational therapy education is generally not based in high status universities, some occupational therapists have left the profession because of lack of status and it is still not well known in lay culture. Emphasising the value of

occupational therapy to society, through appropriate means, carries the potential for enhanced status, if that remains an aspiration.

The implication of failing to agree, on a national scale, that there is a unique skill is that the claim to professional status falls at the first fence. It is therefore an imperative to claim uniqueness. Once this has been done, the ways in which occupational therapy knowledge can be progressed become clearer. Decisions can be made based on answers to the following questions:

- Should occupational therapy knowledge continue to change to fit in with the scientific medical model? This question has often been raised (Stewart 1994; Kelly 1996; Creek 1997) but has not been resolved. Failure to do so further restricts professional identity.
- What are the alternative types of knowledge that might be appropriate?
- What types of knowledge would be of most benefit to service users?
- How can the value of occupational therapy to society be advanced?

Promotion of a unique skill provides an opportunity for the profession to make authoritative statements both publicly and to governments about related issues. Other professions have demonstrated how they have used the media for self-publicity. In one recent example the Society of Chiropractors and Podiatrists highlighted their cause, through the national press, by raising concerns about the consequences to foot health of ill-fitting shoes (Bestic 2004). A study conducted by Roger Harrabin explored media coverage of health related issues. Media reporting was found to be very influential. The priorities and decisions of policy-makers within government are often shaped by what appears on television, the radio and in newspapers. The Government gave a high priority to reducing NHS waiting times after extensive press coverage, for example, although this may have been at the expense of other health-related initiatives. Members of the public have been known to alter their behaviour partly as a result of information they obtained from the media: notably the adverse reaction to the MMR vaccine. But the media tend to focus on dramatic crises such as the severe acute respiratory syndrome (SARS) virus rather than public health issues, measures to improve health, prevent illness or reduce health inequalities. Among other things the report called for 'stronger advocacy for public health issues at national, regional and local levels' (Harrabin 2003).

The time is ripe for allied health professionals to exercise their voices with respect to the issues about which they have explicit knowledge. The National Association of Paediatric Occupational Therapists did just that by publicly supporting the claim by teacher's union the NASUWT that government policy to integrate special needs children into mainstream schools is failing (Hunt 2004). This can only be commended. Conversely, allied health professions have been criticised for failing to recognise the signs of elderly abuse in the home, residential care, hospitals and sheltered housing (Godfrey 2004; Doward 2004). An opportunity was missed to publicise the role that occupational therapy could

play in improving the lives of the elderly. Professionals have been excluded from policy-making since Thatcherism but Foster & Wilding (2000) argued that, providing self-interest is restrained, they still have a significant part to play in the process. Challenging government policies that compromise occupational therapists' ability to perform the job satisfactorily because they focus on speed of patient throughput rather than quality of care, for example, is a collective way for the profession to act as the patient advocates they claim to be. Not to do so, according to Freidson (1994) reduces staff morale, motivation and commitment.

Control of Entry into Professional Practice

The practitioners' perception of university based education was that it was helpful for status and credibility. However, the implications were that it could attract the wrong sort of person into the profession, it was difficult to screen out failing students, it denied an opportunity to those with potential but who did not have the academic ability and it provided poor preparation for the job. They considered that people who do not understand practice produced theory and that theoretical and practical knowledge has become too divergent to be helpful.

The collective view of COT and educators was that academic education was necessary for status and credibility and that professional control of curriculum content was strong. Nevertheless, individuals expressed the same concerns as the practitioners. The CPSM representatives recognised the potential threats to professional education, posed by the dominance of universities and the business ethos. This was interpreted as conflict between the art (necessary for practice) and scientific (necessary for status) dimensions of the profession. Educators can and do resist some of the pressures brought to bear by academic organisations but the fact that they have to do so makes it an adversarial relationship. Business implications often get in the way of effective control into professional education. The result has been a weakening of the gate-keeping role of the profession. It could be argued that because graduate entry is now universal for the health professions nothing much has changed from the diploma era. Possession of a degree has not provided immunity from competition for status, struggles for monopoly and the risk of encroachment. Such games are played out just the same. Competence remains the greatest marketable factor for the professions. Ensuring that begins with the power to control who is and is not suitable for professional education. The importance of a pre-selection exercise, which may or may not be an interview, has been underlined. The implications of not screening, in addition to academic ability, for personal attributes; trustworthiness, a future self that includes an inclination to act ethically, a sense of duty and so on, carries a risk that the socialisation process could be less effective.

Occupational therapy can learn useful lessons from nursing, one of its reference groups. The alignment of nursing to science has come under critical review recently. Kelly (2004) warned that the introduction of highly technical procedures in critical care nursing has threatened holism, an aspect of the profession that is treated with respect and cynicism in equal measure. Nurses' roles have been

extended to include tasks that would normally be performed by a doctor, partly due to the European directive to reduce junior doctors' hours. This has had implications on their own workload and encouraged nurses into medical roles. Whilst nursing regards a combination of science and art to be beneficial for patient welfare, in Kelly's opinion, critical care nursing has allowed science to overshadow art. The consequence has been that highly academic nurses are elevated to posts that remove them from direct patient care and attributes like altruism, empathy, insight and compassion have disintegrated. The result is a public perception that nurses have become too academic to care.

Kelly argued that scientific education undervalues social caring and knowledge gained from direct experience, concluding that nurses need to be more assertive in developing their own body of knowledge independent of medicine and other biological sciences (Kelly 2004). The findings of this study have confirmed that occupational therapists have the same fears. It has been established that knowledge derived from practice prepares students better for the workplace (Jenkinson & Brotherton 1995a; Higgs & Titchen 2001). Eraut (2000) suggested that the theory/practice divide would not be narrowed until the significance of theory implicitly developed in practice is considered favourably in comparison to unrealistic espoused theory that is developed within academia. Taking a closer look at knowledge and theory development within occupational therapy creates the possibility of rationalising those theories it should adopt. It would identify any that can be eliminated and those that are built on the tacit knowledge of practitioners. From that stance it becomes clear which would accommodate the 'caring for', artful aspects of the work, that guide practice effectively and those that link directly to methods of inquiry with the capacity to evaluate the worth of intervention. As a result the profession would regain stronger control of education. This begs the questions:

- What is an appropriate balance between the art and science dimensions of occupational therapy?
- How should knowledge and theory development occur?
- How should the choice of theory be moderated?
- How can the tacit knowledge of practitioners generate explicit theory?

Entrance to the Profession

Having a register listing those suitably qualified, along with legal protection of title, controls entry to the profession. The Health Professions Act (Department of Health 1999) demands greater regulation of this privilege. Practitioners believed that state registration should indicate competence and assure public safety. They had internalised the idea that occupational therapists were best placed to judge one another but at the same time acknowledged self-regulation had been weak. Character screening of potential recruits was essential but difficult to implement. Protection of title was welcomed for providing exclusivity of work but was also seen as a symbolic guarantee of competence. This was a view universally held by

each of the groups. The role of COT involved protecting the work of occupational therapists and public activities, rather than public safety measures, which were attributed to the regulatory body and academic institutes. But the entire cohort accepted that the monitoring of competence needed to be strengthened.

The organising body, during negotiations for the Health Professions Act (Department of Health 1999) managed to avoid excessive government control of professional standards; for example, the profession is accountable to the Privy Council rather than a Minister of Parliament. Nevertheless, the Government has, through the proposals in *Agenda for Change* (Department of Health 2003), strengthened state regulation of the allied health professions. This was the result of a lack of trust by the state that professions could assure competence (Foster & Wilding 2000). One of the proposals is that new graduates will serve an initial foundation period of preceptorship for 12 months; something recommended by Blom-Cooper in 1989 and ignored. Before they can progress through the pay bands, those responsible for the relevant professional standards in an organisation, must be satisfied that staff are applying the basic knowledge and skills needed for the job. The Health Professions Council, along with the College of Occupational Therapists, the Quality Assurance Agency, health and social care providers and individual departments will each interpret these proposals. The new challenge is for them to demonstrate that they can be rigorous in their implementation.

If the profession does not have effective screening of potential recruits, the capacity to weed out the incompetent and to discipline when necessary, then trust will be further reduced. A commitment has been made to the state that competence can be guaranteed and will be monitored. If competence cannot be assured, state registration loses its power as a symbol and status will decline. Therefore it is in the profession's interests to fulfil that promise. Against this background of expectations of competence, the state makes judgments about welfare provision in terms of outcome measures and other statistical information. It wants quantity and quality but practitioners reported that their increased workload has compromised their capacity to provide a good service. Once again the profession could exercise an advocacy role by highlighting the incompatibility of these two ambitions. Future research might evaluate preceptorship and its influence on the ability of occupational therapists to perform the job well. Appropriate questions might be:

- To what extent are procedures for monitoring competence effective?
- To what extent does government policy inhibit occupational therapy practice?

Code of Ethics

Practitioners viewed a code of ethics as a symbolic but powerful internal policing mechanism, the significance of which, COT failed to appreciate. Its tenets are communicated through interactions with the public for whom a code represents

'professional behaviour'. Therefore the perpetuation of ethical behaviour is cyclical; the public expects ethical behaviour and professionals provide it, and because they do so, the public continues to expect it. It is the code driving the process. It was considered an effective control mechanism and generated enhanced esteem because of the association with 'high calling'. Social identity was further consolidated because a code encouraged cohesiveness and professional unity. However, COT was not perceived as having a strong ethical influence on its members and indeed the interpretation of the professional body was different to the practitioners. Collectively, a code of ethics was highly regarded as a public affirmation of the standards to be expected, it could be influential in negotiations with government and other agencies, it was beneficial for image and to ensure that members were of 'good standing'. Yet, individuals within COT doubted that a code influenced behaviour; practitioners would be expected to behave ethically independently of the existence of a code. The code, as a symbol, was not seen as a priority. Perhaps this is indicative of too close an alliance to traditional values wherein ancient professionals were expected to behave in a 'gentlemanly' manner regardless of a formal code.

Socialisation is an important mechanism for instilling ethics, as the educators testified, but the formal, written code is a significant structure in the eyes of practitioners. As far as CPSM was concerned, although a practitioner cannot be disciplined for a breach of the code of ethics, it underpins statutory disciplinary procedures. Notwithstanding the weakness of the link in reality, membership of COT gives a perception that practitioners are willing to adhere to ethical principles. The code therefore is an important symbol for the communication of attributes such as trust and honour. Communicating the link between the professional body and ethics is helpful, not just symbolically but so that ethics is reinforced as an active part of an individual's day to day life. This consolidates the notion of trustworthiness.

COT saw non-membership of the professional body as a lack of professionalism but the practitioners did not share this interpretation. Most joined for the indemnity insurance. Fear of litigation was one of the factors that encouraged practitioners to abide by the code of ethics. There is a risk that it could lead to defensive practice and therefore there is an obligation for the content to be carefully managed. The American Psychological Association developed a code of ethics from cases provided by its members (Miles & Huberman 1994). Involvement of practicing occupational therapists in future reviews offers COT the chance to engage them in an important process, give voice to their opinions and encourage professional unity. Encouraging people to join COT, not just for the insurance, but because they believe they are subscribing to an organisation that monitors behaviour and takes ethics seriously will pay dividends in terms of the interaction between the organisation and individual members. Similarly, there are signs that having a moral dimension to a profession, affirming trustworthiness are once again going to have significance (Foster & Wilding 2000; Nixon 2001).

Those professions that can demonstrate this attribute will enhance their marketability. Suitable questions, to address therefore, might be,

- What are the ways in which practicing occupational therapists can contribute to the code of ethics?
- What are the ways in which a moral dimension of occupational therapy can be advanced?

Service Ideal

Do practitioners possess an ideal of service? From their stance, altruism could disadvantage a profession: it could be manipulated towards accepting poor pay and carried the risk that practitioners would be overburdened. There was a tendency to believe that government strategies rendered altruism impossible to implement. The drive to increase patient numbers leads practitioners to act as authoritative experts, which denies patient choice, despite the profession's claim to be client-centred. Although some individuals enjoyed working in low status areas and most derived intrinsic value from their work; doing the job well for the benefit of society, the majority were interested in gaining status through glamorous work settings. One of the rewards was in developing a 'good reputation' and this was often associated with areas of work with a science or medical base. Yet the same practitioners have questioned the profession's link with science. Status is a powerful motivator and it may be that, as it stands, the easiest way to achieve it is through a scientific route. High caseloads have made it difficult to perform the job well and many reported that their role had been reduced to that of 'technician'. Lack of professional control about what form the work should take, prevents occupational therapists from being able to perform the work as they see fit, which carries implications. Too fast a throughput; too much emphasis on outcome measures and resource limitations restricts their ability to implement a service ideal and the rewards are reduced. Since they cannot do the job as well as they would like who can blame them for being attracted to glamorous jobs, which at least offer some reflected glory?

Collectively, occupational therapists do not work in the best interests of patients because it is harder to recruit staff in areas of greatest need, the elderly, mentally ill and so on. Each of the groups interpreted this as inequitable service provision, demonstrating minimal social responsibility or caring, which perpetuates the stigmatisation of certain sections of society. So occupational therapists do not have an altruistic service ideal but when they find the work stimulating and interesting they do their best for their patients. COT and educators promote the benefits of all aspects of health and social care but existing attitudes might be challenged with questions such as:

- Do occupational therapists want to offer a more equitable service?
- If so, how should interest in low status areas of work be encouraged?

- What are the ways in which occupational therapists can contribute to the reduction of stigmatisation in society?

Socialisation

Eraut (2000) made a distinction between codified knowledge, also known as public knowledge or propositional knowledge and personal knowledge, which he defined as 'the cognitive resource which a person brings to a situation that enables them to think and perform'. This can incorporate codified knowledge but also other types, including skills and 'knowing how' and it concerns the context and manner of its use. Much of this knowledge, according to Eraut, is acquired through non-formal learning, which involves implicit learning (where there is little intention to learn and an absence of explicit knowledge about what was learned) and can generate tacit knowledge. Implicit learning affects behaviour and is influenced by personal experiences and generalised knowledge that enter the memory. Socialisation is an example of implicit learning where individuals learn the norms of an organisation without being aware of that learning or what some of the norms are: leading to tacit knowledge (Eraut 2000).

This study was an attempt to make explicit, that tacit knowledge learned by occupational therapists. Socialisation occurs in academic institutions, clinical fieldwork and throughout professional life. Other people were important in the process of adopting the professional role. When 'others' treated individuals in a manner appropriate to their position it confirmed self-perception: they must be 'in the role'. There were occasions when people identified with the role but were not accepted in it by others and when individuals were not ready to carry out the role but others expected them to do so. Role models were the most significant routes through which individuals learned the tacit norms that were required. A continuum has been identified along which transformations of self-perception occurred, mapping the acceptance of professional status. Markers, or turning points, indicate that a change has occurred, which can be explicit, such as the award of a degree or implicit, such as the being able to respond rapidly to a complex question. Socialised occupational therapists were expected to be: expert, competent, capable, ethical, reliable, diligent, practical, organised, kind, calm and warm. In addition they should have: high standards, good interpersonal skills, communication skills and a sense of humour.

In a sense these were the explicit attributes that the respondents were able to articulate once they were prompted. They represent the aspects of behaviour and self-presentation that make the occupation special and therefore worthy of the professional title. These features are essential for social closure (Macdonald 1995) and are therefore important strategies for the occupational therapy market. The underlying intentions were also evident. The practitioners were seeking status and social identity, from which they derived esteem. Throughout their deliberations about the symbol of professionalism, competence and

trustworthiness were key concepts; they were the genesis of status. Without them, they had no status. But competence, in their view, was being compromised by the conflict between the art and scientific dimensions of occupational therapy, by the loss of control of training into practice, by the divisions over theory, by poor self-regulation. Trustworthiness was at risk without an effective code of ethics and strict monitoring. The consequence has been that 63% of these practitioners had no long-term commitment to the profession. This explains why glamorous jobs were important for them. It is more difficult to have a high reputation in stigmatised areas of work so they tended to take the easier option. More difficult but not impossible: Dr Paul Brand achieved great eminence through his work with leprosy patients, for example. He had extensive expertise but had an intuitive understanding of the artful dimension of his work and is remembered as 'an outstanding example of a medical professional who puts a patient's interests and feelings at the centre of a consultation' (Wim Brandsma 2003). The issue of how to get occupational therapists interested in low status areas of work cannot begin to be addressed until they are confident that competence and trustworthiness can be assured. Once that is achieved, attention can be directed towards socialising occupational therapists in a way that allows them to discover intrinsic worth in care of the elderly through the confident application of a visible and worthwhile skill.

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APPENDICES

Appendix 1

Appendix 1: INTERVIEW SCHEDULE FOR OCCUPATIONAL THERAPY PRACTITIONERS

INTRODUCTORY QUESTIONS

- Did you come straight into OT or have you had another job?
- Where did you do your training?
- How long ago was that?
- Was it a degree or a diploma?

MONOPOLY OF KNOWLEDGE

- I'd like to start by talking about OT skills. Physiotherapists are good at promoting themselves as the only profession skilled at manipulation of the human body. What do you think is the unique skill of occupational therapy?
- OT's deal with basic problems of daily life and sometimes the skills that an OT must have to solve these problems, can *appear* simple. How difficult is it, do you think, to acquire those skills?
- In your day to day work do you still use much of the theory that you were taught during your training?
- There may be some tension between OT's who think that their work should be more scientific and theory based and those who think that they need to be more practical. Where do you stand on this? Why is that?
- Occupational therapy language has become more scientific over the years. There are phrases like 'cognitive and psychosocial components' and 'models of practice'. Is this necessary or helpful do you think?
- I'd now like to introduce the idea that, although there is concern about building rapport with patients, you are advised not to get too close. To put things on a formal footing, some OT's would rather patients call them by their title - Mrs./Ms/Mr. so and so. But others opt for their Christian names to be used. Do you have any preference? Why is that?
- Many occupational therapists wear a uniform and people might use facilities like staff rooms and separate toilets, which help to create a

distance between therapist and patient. Do you think these things are important? Why is that?

- As you know the professional body is the COT. How much authority or power do you think COT has in deciding what the work of an OT should be?

CONTROL OF TRAINING INTO PROFESSIONAL PRACTICE

- What do you think of OT education being university based?
- Is a degree an appropriate qualification for an OT?
- When you trained, were your tutors in touch with clinical skills? Is that important do you think?
- During education, who should be responsible for weeding out OT students who are unsuitable?
- When you were a student what did you consider were the essential things to study?
- What are the tedious aspects of your work? What are the aspects that you really enjoy?

ENTRANCE TO THE PROFESSION

- Have you ever given much thought to state registration? What does the term mean to you? Is it important do you think?
- How do you feel about protection of title for OT's - the legal enactment that someone without a state-registered qualification cannot call themselves an OT?
- I wonder what would happen if people with a criminal conviction - say, a benefit fraud, were allowed to train as OT's?

CODE OF ETHICS

- Every two or three years a new code of ethics is published... I have one here... have you glanced at it recently?
- What is the place of ethics in your day to day work?
- What do you think would happen if we didn't have a code?
- What do you think would happen if we didn't have COT?

- Does it alter someone's standing if they are not a member of COT?

SERVICE IDEAL

- I wonder whether or not you think occupational therapy is altruistic?
- What are the attractive fields of OT? Why is that? What are the unattractive fields? Why?
- There is always a shortage of OT's in the care of the elderly and competition for posts in neurology, for example. What do you think that says about the service that OT provides?
- When you are planning treatment, how much involvement do you like your patients to have? Who decides when to discharge, you or your patient?
- Money is important, but it isn't the only reason for choosing OT as a career. What other rewards, do you think, are important?

SOCIALISATION

- What did you know about OT before you trained?
- When you were a student, what direction did you see your OT career going? Did that change after you qualified?
- While you were training did you expect to have 'learned it all' by the time you qualified?
- Tell me about your fieldwork placements... how useful were they in expanding your clinical experience?
- Was there anyone you met during training who you thought of as a good role model? What were/would, be their qualities?
- Was there a point when you began to feel like an OT?
- Can you remember when you began to feel responsible for your patients?
- Can you pinpoint a time when you were able to explain something to a patient, confidently, in lay terms?
- As an OT, do you consider yourself to be a professional person?

- Would you ever consider leaving OT?

**Appendix 2: INTERVIEW SCHEDULE FOR COT MEMBERS/
EDUCATORS/CPSM MEMBERS**

MONOPOLY OF KNOWLEDGE

- What do you think is the unique skill of OT?
- How does COT/CPSM convince the government that OT has a unique skill?
- Tell me about the ways in which OT has been/is being tied to science. Why is that important do you think?

CONTROL OF TRAINING INTO PROFESSIONAL PRACTICE

- Has university education had the effect COT/educators/CPSM hoped for? What have been the plusses and minuses?
- How do you see OT education changing in the future?
- Who has control over the content of OT education programmes? Where do the threats come from?

CONTROL OF ENTRY INTO THE PROFESSION

- What is the COT/educators/CPSM view of a competent OT at the point of qualification?
- What are the ways in which COT/educators/CPSM can ensure that no one is allowed into the profession who is likely to threaten public safety?
- How does COT/educators/CPSM convince the government that state registration should be maintained?

CODE OF ETHICS

- What do you see to be the role of the code of ethics?
- How is the content of the code decided?
- Those who don't subscribe to the journal don't have easy access to the code – is this important do you think? Why is that?

SERVICE IDEAL

- I wonder whether or not you think occupational therapy is altruistic?
- Some fields of OT are more attractive than others – there are shortages in some areas and competition in others. What do you think this says about the service that OT offers?
- How can COT/educators/CPSM encourage equity of service provision?
- Money is important – but it isn't the only reason for choosing OT as a career. What other rewards are important do you think?

SOCIALISATION

- The way that individual practitioners interact with the public is the embodiment of the image of OT that COT/educators/CPSM intends to present to the world. What is the professional image you want OT practitioners to portray?
- What do you think are the ways in which OT's learn the nature of this image?
- Once trained how long do you expect OT's to remain in the profession?

Appendix 3: GATEKEEPER LETTER

Name and address of researcher
Contact details
Date

Name of gatekeeper
Address

Dear

Re: The Professional Identity of Occupational Therapists
Request for interview respondents

I wonder if I may request some assistance with my PhD, the focus of which is the professional identity of occupational therapists.

The aim of the research is to elicit the ways in which occupational therapists interpret the world of professionalism on a day to day basis. Using in-depth interviewing as the main method of investigation, data are being gleaned from the first hand experiences of practitioners, the organising body, the regulatory body and from educators. The results should have some practical benefits for the profession in the future.

With your permission I propose to conduct a number of interviews from within the practicing membership in this region. As a prelude to approaching people, I would be grateful if you could forward a list of the qualified occupational therapists who are currently employed in your service, along with a contact address and telephone number. I would like to emphasise that acquiescence to an interview is voluntary.

Thank you in anticipation of your help

Yours sincerely

Appendix 4: Guidelines used when giving information to potential participants (based on Cohen & Manion 1994)

Study title: What are the ways in which occupational therapists consider themselves to be professional people?

Researcher: Rosemarie Mason

The purpose of the study:

- To investigate the concept of professional identity from the perspective of practitioner occupational therapists
- To investigate the concept of professional identity from the perspective of COT
- To investigate the concept of professional identity from the perspective of educators
- To investigate the concept of professional identity from the perspective of CPSM
- To investigate the implications for future education and practice

Why the participant was chosen

The participant has been invited to take part in the study because they are a practitioner of ... grade in... type of work setting/member of COT/CPSM/educator.

Self-determination

The participant is under no obligation to agree to participate in this research and can withdraw at any time.

What participation in the study will involve

Participants will be invited to undertake a one-to-one in-depth interview. The interview will be at a time and place convenient to the participant.

What the participant will have to do

Participants will be asked about their views on aspects of professional identity and occupational therapists. The interview will be tape-recorded with permission and is likely to last for about one hour.

What are the possible disadvantages of taking part

There are no anticipated disadvantages to taking part in the study.

What are the possible benefits of taking part

Participants will have the opportunity to contribute to the debate about professional identity. The data will provide an overview of the professional status of occupational therapy at this point in time. The positive and negative effects of what has happened within the profession can be identified. This will help to indicate the type of action likely to be most productive in the future and in what ways.

Confidentiality

The raw information, including audiotapes will be kept securely and will not be accessed by anyone other than my supervisor or myself. The audiotapes and transcribed data will be destroyed when the study is complete. All of the

data collected will be anonymised so that nothing will appear in the thesis that could identify a participant.

What will happen to the results of the study

The study will form my PhD thesis, a copy of which will be placed in the libraries of Sheffield University and the College of Occupational Therapists.

Who is supervising the study

... at Sheffield University.

Appendix 5: Letter confirming consent

Name and address of researcher

Contact details

Date

Name of participant

Address

Dear...

The Professional Identity of Occupational Therapists

Thank you for agreeing to be interviewed about this topic.

I am writing to confirm that our appointment is on ...(date)... at ...(time)...
at ...(venue)...

I am interested in your perceptions of professional identity both in terms of what it means to you and the ways in which the image of occupational therapy is managed. The intention is to look at the topic from the perspectives of practitioner occupational therapists, members of COT, CPSM and educators. The results should have some practical benefits for the profession in the future.

With your permission the interview will be tape-recorded and it should last for an hour to an hour and a half. I would be grateful if you could arrange for a quiet room to be made available.

Yours sincerely

Appendix 6: MONOPOLY OF KNOWLEDGE CODES AND CATEGORIES

CODE	CATEGORY
ACT = activity EAA = environment, adaptation and analysis DL = important to daily life	Unique skill of OT
CS = common sense PRAC = developed with practice IS = inter-personal skills MAT = maturity APT = aptitude DTL = difficult to learn NDTL = not difficult to learn ANY = anyone could do this job	Difficulty of skill acquisition
DNUT = does not use theory UHT = uses hard theory UABS = abstract theory ATI = abstract theory inappropriate TUFJ = theory unnecessary for the job UEJ = unrealistic expectations of the job DES = de-skilling AT = adapts theory	Theory
CRED = credibility CON = concerns EXC = exclusion of non-qualified SMNA = scientific methods not appropriate to OT COMP = science is good for competition PA = practical ability is more important than science BAL = balance between science and practice is important	Tying practice to science
CBI = creates better impression MNH = mystification is not helpful JOU = journal UFC = useful for competition OCJ = over-complicates a simple job DM = used as a defense mechanism	Mystification

CODE	CATEGORY
------	----------

DNI = distance is not important
DII = distance is important
WHL = work and home life
RP = reflective practitioner
EP = expert practitioner
DR = dress
PAT = patients
CLI = clients
BOTH
S/U = service users
NAM = name

Distance

SM = some power
LINF = little influence on professional knowledge
COTMI = COT should have more influence

Power of COT

TABLE 2: Number of times each category for Monopoly of Knowledge was mentioned

Grad = graduate
Dip = diploma

BG = basic grade
Snr = senior

CATEGORY

GRADE OF STAFF

Skill	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
ACT	8		2		1	3	1	1	19 (53%)
EAA	1		5	2	1	4		2	17 (47%)
DL	5		1		1	4		3	16 (44%)

Skill Acquisition	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
CS	5		2	2		1		2	12 (33%)
PRAC	1		2	1		3		1	8 (22%)
IS				1				1	2 (5%)
MAT			2						2(5%)
APT	3		2			3		3	11 (31%)
DTL	2		4					4	10 (28%)
NDTL	2				2	2		2	9 (25%)
ANY			1		1			2	4 (11%)

Theory	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
DNUT	4		4		1	5		5	19 (53%)
UHT	3		2	1		2		2	10 (28%)
UABS	2		3		1	1	1		8 (22%)
ATI	1					1		2	4 (11%)
TUFJ	1		2			1	1	2	7 (19%)
UEJ	3		1			1			5 (14%)
DES								1	1
AT	1			1	1			1	4 (11%)

Tying to science	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
CRED	1		3		1	1		2	8 (22%)
CON	1				1			3	5 (14%)
EXC	3								3 (8%)
SMNA	1					2		2	4 (11%)
COMP	1						1	1	3 (8%)
PA	2			1	1	2		1	7 (19%)
BAL	5		4	1		4	1	1	19 (53%)

Mystification	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
CBI	2		3	1	1	1	1	1	10
MNH	5		2		1	4		5	17 (28%)
JOU	3		5	1	1	6	1	2	19 (47%)
UFC	1					2		4	7 (19%)
OCJ	1		2	2		2		1	8 (22%)
DM	1		1						2 (5%)

Distance	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
DNI	1								1
DII	5		4	2	2	4	1	4	22 (61%)
WHL	4		1			3		2	10 (28%)
RP	6		6	2	1	4	1	6	26 (72%)
EP	7		5	2		5	1	6	26
DR	6		4	2	1	4		6	23 (65%)
PAT	5		5		1	2	1	2	16 (44%)
CLI	2		1	1		1		2	7 (19%)
BOTH	1		1	1		3		3	9 (25%)
S/U						1			1
NAM					1				1

Power of COT	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
SM	6		2	1	1	1		3	14 (39%)
LINF	3		5	1	1	7		3	20 (56%)
COTMI	2		2			3	1	5	14 (39%)

Appendix 7: CONTROL OF TRAINING INTO PROFESSIONAL PRACTICE CODES AND CATEGORIES

CODE	CATEGORY
------	----------

GOOD = university training is a good thing **University education**

SOC = good for social life

STAT = good for status

BAD = university training is a bad thing

ENT = concerns about entry requirements

EXP = the course allows some people to achieve an academic level beyond their expectations

SCRE = concerns about screening procedures for entry to training

ACAD = academic study is prioritised at the expense of practical skills

PGOT = concentration on academic ability denies an opportunity to people who have the potential to be good OT's

WROT = concentration on academic ability can attract the wrong sort of person

PWLR = one of the mores taught by universities is that practical work is for the lower ranks

GTN = graduate training has not necessarily produced better OT's

GTNJ = graduate training does not prepare OT's for the job

PAIT = problems arising from inadequate training

COMP = with diplomate training there was an expectation that students would be competent once qualified

YES

Appropriateness of a degree

WSR = with some reservations

FTOG = follows the trend of other reference groups

STAT = for status

OPSI = orientates the profession to scientific ideology

NO

YES

Tutors in touch

NO

SOME

EUCM = it is important that educators are up to date on clinical matters

CODE	CATEGORY
------	----------

CS = clinical supervisors

Weeding out unsuitable students

EDUC = educators

COMB = combination of supervisors and educators

FAIL = some clinicians find it difficult to fail students

UFA = universities find it difficult to fail students

SCAR = scarcity of OT's can influence the decision

NEG = gives out a negative impression

EXP = some clinicians have personal experience of unsuitable people qualifying

GTIM = having a good time

PASS = passing assignments

HT = hard theory

Essential things to study

PHE = patient handling experience

EMPH = the emphasis at university is on abstract theory

EVER = everything

PRAC = practical skills

PAP = paperwork

PWC = poor written communication

SPAT = some patients

POT = promoting OT

SS = staff shortages

Tedious aspects of work

TS = training staff

WP = work politics

STIM = shortage of time

SRES = shortage of resources

PC = patient contact

TO = training others

DS = developing a service

RES = research

Enjoyable aspects

TABLE 3: Number of times each category for Control of Training into Professional Practice was mentioned

Grad = graduate
Dip = diploma

BG = basic grade
Snr = senior

CATEGORY

GRADE OF STAFF

University education	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
GOOD	3		1	1	1			2	8 (22%)
SOC	1						1		2 (5%)
STAT			3	1	2	3			9 (25%)
BAD			1			1			2 (5%)
ENT	1		1			1			3 (8%)
EXP	2		1		1				4 (11%)
SCRE						2		1	3 (8%)
ACAD	5		2			4		6	17 (47%)
PGOT	2							1	3 (8%)
WROT	3		2			1		1	7 (19%)
PWLR			2						2 (5%)
GTN	1							1	2 (5%)
GTNJ	5		3		1	3		5	17 (47%)
PAIT	2		1			3		1	7 (19%)
COMP						1		1	2 (5%)

Degree appropriate?	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
YES	2		2	2		1		2	9 (25%)
WSR	2		4			1	1	3	11 (30%)
FTOG			1		1	3		1	6 (17%)
STAT	2							2	4 (11%)
OPSI								1	1 (3%)
NO	1				1	2		2	6 (17%)

Tutors in touch	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
YES	3		3	1	1	2		2	12 (33%)
NO	1		1			4	1	4	11 (30%)
SOME	5		3	1	1	1		2	13 (36%)
EUCM	1		3	1		4		3	12 (33%)

Weeding out poor students	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
CS	4		2					1	7 (19%)
EDUC	1		1					3	5 (14%)
COMB	3		5	2	2	6	1	4	24 (67%)
FAIL	4		5		1	3		4	17 (47%)
UFA						1		5	6 (17%)
SCAR	1			1				3	5 (14%)
NEG			1		1			4	6 (17%)
EXP	2		1		1	3		3	10 (28%)

Things to study	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
GTIM				1		1			2 (5%)
PASS	2		1		1	1			5 (14%)
HT	7		4	2		4	1	6	24 (67%)
PHE	1		4	1		1	1	1	9 (25%)
EMPH	2		1						3 (8%)
EVER					1	1			2 (5%)
PRAC						1	1	1	3 (8%)

Tedious aspects	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
PAP	8		6	1		6		7	28 (78%)
PWC	1				1				2 (5%)
SPAT	2		1	1		4		1	9 (25%)
POT					1	1		1	3 (8%)
SS					1			1	2 (5%)
TS						2			2 (5%)
WP								1	1 (3%)
STIM	3		1		1				5 (14%)
SRES					1			1	2 (5%)

Enjoyable aspects	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
PC	9		7	2	2	7		6	33 (92%)
TO							1	1	2 (5%)
DS								2	2 (5%)
RES			1						1 (3%)

Appendix 8: ENTRANCE TO THE PROFESSION CODES AND CATEGORIES

CODE	CATEGORY
PS = policing should be more stringent	State registration
UNC = unclear as to the purpose of state registration	
BLUR = The concepts of state registration and protection of title are blurred	
DIS = it helps OT's to discipline themselves to keep up to date	
COM = signifies competence	
GT = graduate training does not guarantee competence	
GOOD = good idea	Protection of title
REA = reassurance of competence	
EXC = excludes others	
FOR = follows other reference groups	
LBW = although OT's would like to show leniency they have worries	Character screening
TIC = trustworthiness is compromised	
NAP = not a problem	

TABLE 4: Number of times each category for Entrance to the Profession was mentioned

Grad = graduate BG = basic grade
Dip = diploma Snr = senior

CATEGORY			GRADE OF STAFF						
State registra tion	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
PS	2		1		1			3	7 (19%)
UNC	2		2				1		5 (14%)
BLUR	1			1	1	2		2	7 (19%)
DIS	1								1
COM	6		5	1	1	5		5	23 (64%)
GT						1		1	2 (5%)

Protect ion of title	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
GOOD	2		1			3	1		7 (19%)
REA	2		2	1	1	3		1	10 (28%)
EXC	5		4		1	2		5	17 (47%)
FOR				1					1

Charac ter screen	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
LBW	6		6	2	1	5	1	6	27 (75%)
TIC	2					1		2	5 (14%)
NAP	1		1		1	1			4 (11%)

Appendix 9: CODE OF ETHICS CODES AND CATEGORIES

CODE	CATEGORY
RS = rarely studied RR = read regularly	Frequency of the Code of ethics being read
DA = difficult to articulate BR = behavioural restraint INS = ethical conduct is instilled SUB = ethical conduct is subconscious EDM = examples of ethical decision making	Place of ethics
ED = enforces discipline SYM = symbol of professionalism EBC = ethical behaviour would continue	Affects if there was no code
SH = symbolic head CON = confusion INC = inconsequential NOD = it does not alter someone's standing if they are not a member of COT YD = yes it does alter someone's standing if they are not a member of COT UNS = unsure	Affects if there was no COT

TABLE 5: Number of times each category for Code of Ethics was mentioned

Grad = graduate
Dip = diploma

BG = basic grade
Snr = senior

CATEGORY

GRADE OF STAFF

Read code?	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
RS	9		6	1		7	1	5	29
RR			1	1	2			3	7 (19%)

Place of ethics	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
DA	3		1			1			5 (14%)
BR	3		3	2	1	2	1	4	16 (44%)
INS	6		1		1	2	1	3	14 (39%)
SUB	3		2	1		2	1	3	12 (33%)
EDM	3		6		1	6		1	17 (47%)

No code	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
ED	8		6	1	1	7	1	6	30 (83%)
SYM	1		2	1	1			2	7 (19%)
EBC						1		1	2 (5%)

No COT	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
SH	9		6	2	1	6	1	8	33 (92%)
CON					1				1
INC			1			1			2 (5%)
NOD	6		6	2	1	5	1	8	29 (80%)
YD	2				1	1			4 (11%)
UNS	1		1			1			3 (8%)

Appendix 10: SERVICE IDEAL CODES AND CATEGORIES

CODE	CATEGORY
YES	Altruism
NO	
IV = intrinsic value	
PAED = paediatrics	Attractive fields of OT
NEUR = neurology	
HT = hand therapy	
SS = social services	
MH = mental health	
B&P = burns & plastics	
SPI = spinal injuries	
ORTH = orthopaedics	
LD = learning disabilities	
ONC = oncology	
AMP = amputees	
PHYS = physical	
A&E = accident & emergency	
REHB = rehabilitation	
LW = locum work	
ELD = elderly	Unattractive fields of OT
MH = mental health	
LD = learning disabilities	
ORTH = orthopaedics	
SS = social services	
AHW = acute hospital work	
NONE	
PAED - paediatrics	Reasons why some fields are attractive
YD = young disabled	
STAT = status	
PP = personal preferences	
LOI = likelihood of improvement	
NP = nice patients	
SL = staffing levels	
PAY	

CODE	CATEGORY
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DULL = dull or menial **Reasons why some fields are unattractive**
LOLI = likelihood of lack of improvement
PILC = poor image in lay culture
DP = difficult patients

LOA = lack of autonomy
US = uncommitted staff
NPOT = not proper occupational therapy

CEU = care of the elderly is unappealing
GFP = good for the profession **What service shortfalls say about OT**

IWL = involvement with limits **Involvement in treatment planning**
SPI = some patient involvement

OT = occupational therapist **Who discharges?**
MDT = multi-disciplinary team
ND = not discharged
MED = medic

BP = benefitting patients **Rewards**
POT = part of a team
VAR = variety
PRES = prestige
IP = interesting people
FREI = financial recompense for emotional investment
GC = good conditions

TABLE 6: Number of times each category for Service Ideal was mentioned

Grad = graduate
Dip = diploma

BG = basic grade
Snr = senior

CATEGORY		GRADE OF STAFF							
Altruistic	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
YES	4		4	1		4		3	16
NO	1		1		1	4	1	3	11
IV	3		3	1	1	2		3	13
									(36%)

Attract ive fields	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
PAED	5		4	1	1	2		3	16
NEUR	5		2	2		2	1	2	14
HT	3		1		1	1		2	8 (22%)
SS	3					2		3	8 (22%)
MH	1		3		1			1	6 (17%)
B&P	1		1					1	3 (8%)
SPI	1		1	1					3 (8%)
ORTH	1		1						2 (5%)
LD	1		1						2 (5%)
ONC	1					1			2 (5%)
AMP			1						1(3%)
PHYS	1								1 (3%)
A&E						1			1 (3%)
REHB									1 (3%)
LW								1	1 (3%)
								1	1 (3%)

Un Attract ive fields	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
ELD	4		1		2	2		3	12
MH	3		3	1		1		3	11
LD	2		1			1		3	7 (19%)
ORTH	3						1	2	6 (17%)
SS	1		3					2	6 (17%)
AHW	3		1					1	5 (14%)
NONE				1		2			3 (8%)
PAED			1					1	2 (5%)
YD	1								1 (3%)

Reason attractive	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
STAT	5		7	1	1	3		5	22
PP	6		2		2	4	1	3	18 (61%)
LOI	2		3	1		1			7 (50%)
NP	1		1						2 (19%)
SL	1								2 (5%)
PAY								1	1 (3%)

Reason unattractive	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
DULL	6		3			1	1	4	15 (42%)
LOLI			1			1		2	4 (11%)
PILC	1		1	1				1	4 (11%)
DP	1		1						2 (5%)
LOA								1	1 (3%)
US						1			1 (3%)
NPOT									1 (3%)

Service shortfalls	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
CEU	8		7	2	2	4	1	7	31 (86%)
GFP						2		1	3 (8%)

Involve in treatment	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
IWL	8		3	1		2		4	18 (50%)
SPI	1		3	1	2	3	1	1	12 (33%)

Who discharges?	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
OT	6		5	2	1	4	1	5	24 (67%)
MDT	2		1			2		1	6 (17%)
ND			1		1				2 (5%)
MED	1								1 (3%)

Rewards	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
BP	8		6	1	2	7	1	7	32
POT	2					2			(89%)
VAR	2			1	1	1		2	6 (17%)
PRES			1			1			5 (14%)
IP			1			1		1	3 (8%)
FREI						1		1	3 (8%)
GC	1					1			1 (3%)
									1 (3%)

Appendix 11: SOCIALISATION CODES AND CATEGORIES

CODE	CATEGORY
<p>PWE = previous work experience CWOT = contact with an occupational therapist ISO = information sought out</p>	<p>Prior knowledge of OT</p>
<p>RPO = range of possibilities opened DIRS = direction of interest remained the same JWQ = just wanted to qualify</p>	<p>Career direction</p>
<p>YES NO</p>	<p>Expect to learn it all?</p>
<p>NAT = not fully appreciated at the time JP = judged positively USOT = understanding the concept and scope of OT LPB = learning professional behaviour TSOT = transition from student to occupational therapist FWHU = learning on fieldwork is weighted more heavily than that from university</p>	<p>Fieldwork placements</p>
<p>NA = negative aspects GOOD SGRM = supervisor as a good role model CGRM = colleague as a good role model TGRM = tutor as a good role model NRM = no role model</p>	<p>Role models</p>
<p>FSPR = first senior post or position of responsibility CON = contextual FJ = first job DT = during training WSM = within six months WEM = within eighteen months TTY = two or three years</p>	<p>Feel like an occupational therapist?</p>
<p>FJ = first job DT = during training CON = contextual FSP = first senior position NR = does not feel responsible</p>	<p>Feeling responsible for patients</p>

CODE	CATEGORY
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CMLL = conversion of medical language to lay terms

COTL = common understanding of OT language

SJ = in a specialist job

WEM = within eighteen months

FJ = first job

DT = during training

NA = natural ability

NC = not that complex

UR = unable to recall

NYC = not yet confident

Giving explanations to patients

UNS = unsure

NLDR = yes but not like a doctor

YES

Consider self to be a professional?

YES

POSS = possibly

NO

Leave OT?

TABLE 7: Number of times each category for Socialisation was mentioned

Grad = graduate BG = basic grade
Dip = diploma Snr = senior

CATEGORY		GRADE OF STAFF							
Prior knowle dge of OT	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
PWE	1		1			2		1	5 (14%)
CWOT	1								1 (3%)
ISO	7		6	2	2	5	1	7	30 (83%)

Career directio n	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
RPO	8		5	2		3		4	22 (61%)
DIRS			1		1	4	1	2	9 (25%)
JWQ	1		1		1			2	5 (14%)

Learned it all?	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
YES	4		2	1	2	4		6	19 (53%)
NO	4		5	1		3	1	2	16 (44%)

Fieldw ork placem ents	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
NAT	1					1			2 (5%)
JP						1	1	2	4 (11%)
USOT	8		5	3		3		2	21 (58%)
LPB			1		2	2		3	8 (22%)
TSOT			1			1			2 (5%)
FWHU	4		3	1	1	1		1	11 (31%)

Role models	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
NA	2		4			2			8 (22%)
GOOD	1		1					1	3 (8%)
SGRM	8		6	2	1	6	1	6	30 (83%)
CGRM								1	1 (3%)
TGRM	1			1		1			3 (8%)
NRM			1					1	2 (5%)

Feel like an OT?	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
FSPR	1				1	2		5	9 (25%)
CON	1		2			3	1	1	8 (22%)
FJ	1		2	1	1				5 (14%)
DT	2		2			1			5 (14%)
WSM	2		1	1		1			5 (14%)
WEM	1							2	3 (8%)
TTY	1								1 (3%)

Resp. for patient s	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
FJ	2		6		1	1	1	4	15 (42%)
DT	3		1			2		1	7 (19%)
CON	2			2		3		2	9 (25%)
FSP					1	1			2 (5%)
NR	2							1	3 (8%)

Explanation to patients	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
CMLL	4		2		1	4		2	13 (36%)
COTL	4		2	1	1	2			10 (28%)
SJ			3			2	1	1	7 (19%)
WEM				2	1	2			5 (14%)
FJ	5		2		1	1			9 (25%)
DT	2		1			1		2	6 (17%)
NA								2	2 (5%)
NC	1							1	2 (5%)
UR								1	1 (3%)
NYC	2		1						3 (8%)

Consider self to be professional?	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
UNS	1		1			1		1	4 (11%)
NLDR	1				1				2 (5%)
YES	7		6	2	1	6	1	7	30 (83%)

Leave OT?	Grad BG	Dip BG	Grad Snr 2	Dip Snr 2	Grad Snr 1	Dip Snr 1	Grad Head	Dip Head	Total
YES	1		2	1	2	4		2	12 (33%)
POSS	3		2			2	1	3	11 (30%)
NO	5		3	1		1		3	13 (36%)